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HEALTH CARE REFORM (Part 3)

JOINT HEARINGS
BEFORE THE
SUBCOMMITTEE ON HEALTH AND THE
ENVIRONMENT
AND THE
SUBCOMMITTEE ON COMMERCE, CONSUMER
PROTECTION, AND COMPETITIVENESS
OF THE
COMMITTEE ON
ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES
ONE HUNDRED THIRD CONGRESS
FIRST SESSION

NOVEMBER 2, 1993—PROPOSED NATIONAL HEALTH BOARD
NOVEMBER 9, 1993—INSURANCE MARKET ISSUES
NOVEMBER 10, 1993—MEDICAL MALPRACTICE

Serial No. 103-84

Printed for the use of the Committee on Energy and Commerce



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HEALTH CARE REFORM

Proposed National Health Board

TUESDAY, NOVEMBER 2, 1993

HOUSE OF REPRESENTATIVES, COMMITTEE ON ENERGY
AND COMMERCE, SUBCOMMITTEE ON HEALTH AND THE
ENVIRONMENT, AND THE SUBCOMMITTEE ON COM-
MERCE, CONSUMER PROTECTION, AND COMPETITIVE-
NESS,

Washington, DC.

The subcommittees met, pursuant to notice, at 10:04 a.m., in room 2123, Rayburn House Office Building, Hon. Henry A. Waxman, chairman, Subcommittee on Health and the Environment, and Hon. Cardiss Collins, chairwoman, Subcommittee on Commerce, Consumer Protection, and Competitiveness, presiding.

Mr. WAXMAN. The meeting of the joint subcommittees will come to order.

Last Wednesday, the President and First Lady brought to Congress a health care reform bill that I and a number of our colleagues plan to cosponsor. Last Thursday, we heard from the Secretary of the Treasury, the Secretary of Labor, and the head of the Small Business Administration on the impact of the President's plan on the economy.

Today we begin a series of hearings on key elements of the President's plan. Specifically, we are going to get an overview of the structure of reform under the plan, the role of the Federal Government and the new National Health Board, the responsibilities of the States, and the functions of the new regional alliances.

As we consider creating new institutions like the Board and the alliances that will have broad authority to establish health policy and will collect and disperse large sums of money, we need to be very careful about the accountability to the public. We must assure employers and their workers that health plans are providing high quality services for their enrollees.

We must take care to protect the funds provided to purchase health benefits from diversion. We must have effective ways of guaranteeing that all residents of an alliance have access to the benefits to which they are entitled. We need to understand what happens if the capped subsidy pool is not adequate to assure that small employers, low wage workers, and retirees get the help they have been promised. If there is a shortfall of funds, we need to know who bears the financial risk and responsibility.

We are in some uncharted waters here. I believe we must be able to show the American people in advance how this new system

will work for them to bring them the security of coverage that so many lack today.

Before calling on our first witness, I want to recognize members of the two subcommittees that are sitting jointly to make opening comments. And I want to recognize the Ranking Republican, Mr. Stearns.

Mr. STEARNS. Good morning, and thank you very much, Mr. Chairman. Today's hearing focuses on the structure of the National Health Board and the Health Alliances. The National Health Board was described to this committee as, quote, a small support organization, or, quote, minor oversight board. It will have little real power under our new health care system. Yet as I read this 1,300-page—1,300-page-plus document, the Federal National Mandated Health Board will have the ultimate responsibility for one-seventh of the Gross National Product and will virtually control all of our health care system.

In addition, we have additional new responsibilities for Health and Human Services, the Department of Labor, the States and the creation of new government-run entities such as the regional alliances.

Mr. Chairman, we have all seen the track record of big Federal bureaucracies, whether it is the Post Office, the Veterans Affairs, the Internal Revenue Service, HHS, or any other Federal agency. They have proven to be the very things that Vice President Gore is examining in his, quote, reinventing government plan.

As I look at the President's health care bill, I see a structure that is long on government bureaucracy and short on the consumer's ability to navigate through the red tape. We have all emphasized the need for choice, but it appears that the plan's new bureaucracies are making all of the choices, not the consumer.

For example, if a health plan fails to meet the premium caps, the alliance can choose to assess penalties on each plan whose premium exceeds the government-mandated premium inflation factor. Or the alliance could choose to negotiate new premiums with the plans. Or the alliance can choose to not enter into contracts with plans whose premiums are too high. Thus eliminating choices for consumers.

Finally, the Federal Government can weigh in with its own choice. If the State fails to comply with the Federal requirements, the Secretary of HHS can take over a regional alliance. That means that the Secretary must impose a payroll tax to pay for the government's cost in running the plan.

Again, Mr. Chairman, it sounds to me like the ones doing all the choosing are the new bureaucracies in the Federal Government that will be created under this plan. I am concerned there may not be a lot of room for consumer choice under the President's model.

Mr. Chairman, I look forward to hearing from our witnesses on their assessments of the new bureaucracies that are going to be created under the Health Security Act.

Thank you.

Mr. WAXMAN. Thank you, Mr. Stearns.

Mr. Wyden.

Mr. WYDEN. Thank you, Mr. Chairman. I commend you for holding this hearing because I think the regional alliance and the Na-

tional Health Board are central to the discussion of a strong health reform bill.

Regional alliances, of course, are the keystone in the President's proposal. I for one am impressed by the administration's approach in terms of giving consumers a choice of health plans, and I think the administration is on target in terms of offering the point-of-service option for health plans as well.

With the point-of-service option, this country and our citizens are going to see that people can get the health care they want when they want it. And I and others have pushed hard for that point-of-service option and I commend Dr. Feder and the administration for their work in this regard.

There are some other questions, however, that I have about the alliances, and in particular I am concerned that employers with less than 5,000 people seem under what has been proposed to have virtually no incentive to do health promotion work. We have seen great progress in a number of the health promotion programs and it seems to me that employers with less than 5,000 people have very little incentive to do health promotion services or to keep the costs down.

The flip side of it is that employers with over 5,000 people seem to have such a sweeping exemption from the rest of the system that I question whether or not real benefit is going to be derived as well. For example, I question whether it is possible to look at 5,000 people as a risk pool that is truly going to work for health insurance purposes. So I will be anxious to explore those questions with Dr. Feder and her allies this morning.

Finally, I would like to make a point with respect to the National Health Board. It seems to me we have a choice in our country of in effect having de facto rationing, which is what you will have when insurance premiums are capped, and companies bump up against the cap and companies tell subscribers that they have to wait or that they are going to get fewer services than they wish, or we can do as we have done in my home State of Oregon, make decisions through the front door about health care priorities.

I am very interested in exploring with the administration the idea that the National Health Board in particular would be allowed under this legislation to make explicit recommendations about health care priorities for the future.

It seems to me that the Board, as it is constituted, does some very useful work in making recommendations about technologies and I support the administration in that regard. But I think it is important to note that someone in this health system has got to make some tough choices. Someone has got to make some decisions about priorities. The choice is either do it through the front door as we have done in Oregon—and we could do that through the National Health Board—or to permit what I think is inevitable, de facto rationing, which is what we will have when those insurance premiums and the caps kick in.

So, Mr. Chairman, I thank you. This is an important hearing. Dr. Feder has always been a pleasure to work with and we look toward to working with her today.

Mr. WAXMAN. Thank you, Mr. Wyden.

Mr. McMillan.

Mr. McMILLAN. Thank you, Mr. Chairman.

I would also like to welcome to the committee Dr. Feder, who as we all know has been instrumental in the creation of President Clinton's Health Security Act. I am very interested to hear her testimony today on how she views the structure of the administration's plan, both because of its radical effects for the average citizen, and the sheer complexity of the plan as detailed in the 1,300 page document which we received last week and continue to receive this week.

Frankly, I would have preferred that Dr. Feder's testimony begin with the financing of the Health Security Act, since no one in Congress to my knowledge has seen many of the financing assumptions implicit in this plan.

Luckily for my colleagues, I hope, I will have the opportunity to address these issues when Dr. Feder meets with the Budget Committee, tomorrow. I will hope that Dr. Feder and her assistant, Ken Thorpe, will have the answers to the questions that I faxed to her last week following our hearing with Secretary Bentsen and Director Bowles, so that Congress and the American people will finally have the opportunity to see how the President plans to finance the commitments that are made in his statements about health care reform and in the proposal that we have before us.

While we will not have the opportunity to discuss the cost of the plan today, we will have a chance to look at the financial ramifications and impact the President's far-reaching proposals will have on the average American. I hope that Dr. Feder will be able to explain to the committee the mechanism by which health care will be delivered in this country and what its effects will be on individuals and businesses large and small, as well as other institutional employers.

I am especially interested in her views on whether or not this country will continue to have a viable insurance market, given the nature of Mrs. Clinton's remarks as reported today in The Washington Post and The New York Times. I request permission to revise or extend my remarks and yield back the balance of my time.

Mr. WAXMAN. Without objection, your request will be granted.

Mr. Sharp.

Mr. SHARP. No thank you, Mr. Chairman.

Mr. WAXMAN. Well, we are pleased to welcome Dr. Judith Feder, who is the Principal Deputy Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services.

Dr. Feder is recognized as one of the Nation's leading health policy analysts. She served as the executive director of the U.S. Bipartisan Commission on Comprehensive Health Care established by the Congress in 1989. Before assuming her current position, she served as associate director of the Kaiser Foundation—Kaiser Commission on the Future of Medicaid.

Dr. Feder, we are pleased to have you with us. Your prepared statement, without objection, will be made part of the record in its entirety. We would like to have you give us your oral presentation of it.

STATEMENT OF JUDITH FEDER, PRINCIPAL DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY GARY CLAXTON, SENIOR POLICY ADVISOR

Ms. FEDER. Thank you, Mr. Chairman. It is indeed a pleasure to be before you today to participate in the effort to which we are all committed, and you in particular, to achieving comprehensive health care coverage for our Nation's citizens.

I have with me today Gary Claxton, who is my colleague in the Office of Planning and Evaluation in the department, and I would like to proceed with some opening remarks.

I think, as indicated by the opening statements, the committee is quite familiar with the problems the Nation is facing, and I think we are all concerned that consumers in our current environment are at the bottom of the heap in terms of dealing with insurance and control over their access to health care when they need it.

What I am going to talk about today is the structure that the President's plan would put forward that will put the consumer back on top. Let me go through the components for you.

First and most fundamental, the reformed health insurance system must be grounded in a Federal, State, private sector partnership. The President's philosophy is that the Federal Government should establish what is guaranteed to all citizens, and what is expected of our health care system. However, because health care is a local industry and a personal service, it is the States and the private sector that will develop a system to put those guarantees into effect.

Let me describe how the responsibilities in this partnership will work. I will start with the Federal guarantees. You can see on the chart, Mr. Chairman, the array of responsibilities in the system.

The Federal Government, through a National Health Board and the executive branch departments, will set overall standards for the new system. These standards will fix much of what is broken in the current system by providing for: universal coverage for comprehensive benefits, insurance reform with open enrollment and community rating, standardized forms and administrative simplification that lighten providers' paperwork problems, consumer protections enabling consumers to evaluate plans, a quality assurance program to promote quality in all plans, and the availability of multiple plans from which consumers may choose, and finally, control of health care costs through Federal standards that will govern the reorganization of private health care markets to promote competition on the basis of quality, efficiency and service, with a backup system of premium constraints.

How does the Federal Government do its job? First, a national board will be responsible for setting many of the basic Federal standards. The purpose of this seven-member board is to have an expert body focusing solely on developing broad policy to address critical issues in our health care system. The Board is responsible for approving each State's plan for implementing reform, for assuring that premium caps are met, for updating benefits based on changes in medical practice and technology, and for establishing

performance measures for access and quality in the Nation's health plans.

With the Board acting as a Board of Directors, other existing agencies will provide research, legwork and analytic support to fulfill its tasks. In that regard, the responsibilities of the Department of Health and Human Services will include its ongoing responsibilities for Medicare and the Public Health Service programs, overseeing and enforcing State compliance, promoting access and public health through the Public Health Service, and continued support for graduate medical and other health professional education, with a new emphasis on improving the supply of primary care providers. Within these guidelines and supports, States and the private sector will build a system suited to each community's needs.

During the past decade, States have made significant strides toward health reforms that expand access, improve quality and control costs of their citizens. Within a Federal framework of guarantees, they can go the rest of the way. Each State will develop for board approval a plan to provide universal enrollment, provide for a system for collection of premiums, implement insurance reforms, certify health plans, and provide for administration of data collection and quality improvement programs.

State plans will vary as States use the flexibility the President's plan will encourage. States may establish alliances, purchasing pools, and provide for their boundaries, governance and operations subject to Federal guidelines. Alternatively, States may also choose a single-payer framework in which all providers are paid directly by the State or an all-payer framework in which providers are paid common payment rates by all insurers.

For reorganizing the health care market, States will turn to Health Alliances. We have heard a lot about choice in our debate and today individuals, small businesses, and not-so-small businesses, are at a terrible disadvantage in the insurance market.

The President's plan resolves the current fragmentation by bringing together the purchasing power of individuals and groups into buying pools called alliances that are run by employer and consumer representatives. Alliances will be responsible for enrolling all individuals in their area into health plans, providing them with information on health plan features, and administering subsidy systems. These are all tasks that guarantee that it is individuals, not their employers, who are making choices in this system.

Alliances are purchasing pools, not regulatory agencies. Their job is to make the market work. Any health plan that wants to operate in an area does so through the alliance, and the alliance makes all such plans available to its members based on competitive bids, subject to a premium cap. The only exclusion there is, is that alliances have the option to reject plans whose premiums exceed the average premium by 20 percent or more.

Alliances help small employers with relief from their growing health benefits administrative burdens. Alliances help consumers by enabling coverage choices that are easy to understand and by providing consumer protections. Everybody is in a plan and plans will be available to the whole community, including its underserved populations.

Now we turn to how to buy and deliver insurance protection under the plan. First, the role of health plans. All employers will contribute to the purchase of health care coverage for their employees by paying at least 80 percent of the average premium in their Health Alliances or in their corporate alliances.

Based on our current estimates, the required contribution for employers in the Health Alliance will be capped at 7.9 percent of payroll. Additional discounts will be available to small, low wage employers, with fewer than 75 employees. Those small firms—the smallest firms with the lowest wages will be able to purchase insurance for a maximum of 3.5 percent of their payroll, roughly 15 cents an hour for an employer with minimum wage workers.

The self-employed will be able to deduct 100 percent of their health expenses. Employers of sufficient size as well as Taft-Hartley plans and rural electric cooperatives will continue to have the option of self-insuring their employees' health benefits by forming a corporate alliance. Any private employer with over 5,000 full-time employees nationwide may elect to form a corporate alliance. These large employers may also, of course, participate in the regional alliance with community rating and discounts phased in.

A corporate alliance will serve the same functions as a Health Alliance under similar requirements for its employees. Guaranteed comprehensive benefits, annual open enrollment among a choice of plans, and grievance procedures to provide consumer protection.

Now, let me turn to the role of the individual. Let me emphasize every person will choose his or her own doctor and health plan. No employer, no government, no bureaucrat will make these decisions for us. After the employer pays its share, people will be responsible for the remainder of the premium for the health plan of their choice.

For the family share of premium, Federal discounts will be available for people with incomes up to 150 percent of the Federal poverty level, with an additional cap of 3.9 percent of income. Some people, such as part-time workers, may also be responsible for a portion of the employer's share of the premium.

Federal subsidies for this share of the premium will be extended to those with nonwage income up to 250 percent of the Federal poverty level. Thus, the Nation's 37 million uninsured individuals and families, 85 percent of whom are working people and their families, will be able to afford insurance and will be asked to pay their fair share.

Along with choice must come responsibility. Under the President's plan, we will all bear more responsibility for our health care decisions. Consumers will be required to enroll in a health plan and will be responsible for making informed enrollment decisions that best meet their health care needs.

Consumers also will be financially responsible for the choices they make. Those who choose plans with above average premiums may bear the additional costs themselves.

Finally, the health plans. How is insurance provided? Health plans will provide health insurance coverage much as insurance companies and HMO's provide such coverage today, except they will operate under new rules that will turn insurance plans into health plans.

The health plan's job will be to deliver high quality, affordable health care to all of its enrollees within the premium it bids. Health plans will also have to give all consumers about how they deliver care so that they might choose more wisely.

A health plan can be a fee-for-service plan like today's indemnity plans, an HMO, a preferred provider organization or other type of network, or any other arrangement that meets the Federal and State requirements. And there must be at least one fee-for-service plan available in each alliance and there is no limit on the number of fee-for-service plans that an alliance may offer.

In conclusion, Mr. Chairman, there is clearly room for debate about the details of this plan. But the basic principles are clear: All Americans must have health security. Everyone must make a contribution. Health care quality must be preserved and improved. Consumers' choice and access to care must be enhanced. And the rate of inflation must be slowed.

Thank you, Mr. Chairman.

[Testimony resumes on p. 33.]

[The prepared statement and charts referred to by Dr. Feder follow:]

STATEMENT OF
JUDITH FEDER, Ph.D.
PRINCIPAL DEPUTY ASSISTANT SECRETARY
FOR PLANNING AND EVALUATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and Members of the Subcommittee:

We have heard a lot in the past few weeks about the ground swell of support for health reform from the American people. As we set out to answer this call to action, we must start by recognizing that this consensus stems from the plain fact that our health insurance and health care delivery systems suffer from major flaws that threaten our health security. The basic needs of millions of hard working Americans are not being met. The quality of care is often compromised by fragmented and uncoordinated delivery of services and by a lack of useful and widely available clinical information to guide providers. And the cost of health care consumes resources we cannot afford to waste.

The causes of these problems are well understood by this Subcommittee:

* Today, insurers are free to price the sick out of the market. Pre-existing condition waiting periods in most health insurance policies force people who need care to go without coverage for months or years. Fear of losing medical coverage is keeping people in unproductive jobs or on welfare. Insurance companies compete to enroll healthy people, pouring vast resources into identifying those least likely to need medical care, not into providing care to those who need it most. There

is no responsibility to provide education and preventive services, nor to provide the best medical coverage to those at risk.

* Decisions about which health plans are available for enrollment, and what benefits are offered, often are not made by the families whose health care will be affected, but by their employers. This arrangement compromises not only choice, but also continuity of care, when people are forced to change their health plan because they change jobs or because their employer switches carriers. Individuals and families who purchase insurance for themselves are at an even greater disadvantage. With no coherent system for assuring the availability and affordability of health coverage, the consumer has gotten lost.

* For the most part, health plans today are not held accountable for the quality of care their providers render, the efficiency of their customer service, nor their ability to organize hospitals, doctors, and other providers to achieve these ends within a budget. Nor could they be, under today's health system. Our nation has too many doctors who specialize in treating a single type of disease or organ system and not enough who are trained to care for the whole person. Patients with ill-defined health problems may bounce from specialist to specialist, incurring costs for many expensive tests and procedures before they find the care they need. And patients seeking care from the

multiple providers -- even multiple providers within the same health plan -- can be at risk when one doctor unknowingly prescribes medication or procedures that conflict with the plan of care prescribed by another doctor.

* Our system of quality monitoring and assurance also needs significant strengthening, both to protect patients and to assist health care practitioners in their jobs. Today, data on what works and what constitutes quality care is fragmented and hard to access. For too long health care data have been collected with an eye toward what we are spending, not whether we are producing satisfactory outcomes. And for too long, information about what works and why has not been available to practitioners in a convenient, useful, and timely manner.

In light of these problems, it is not surprising that, nationwide, 59% of Americans believe the system needs "a complete overhaul," 75% think that the cost of care in this country is much higher than it should be, 68% worry that they will have health care costs that will not be covered, and 59% are concerned about losing coverage if they change jobs. This is simply unacceptable -- we must put the consumer in the driver's seat.

Mr. Chairman, the demand for reform is a rational response to an irrational system. To address this demand the President has outlined six principles on which health reform must be

founded: security, simplicity, savings, quality, choice, and responsibility. The First Lady and the Secretary of Health and Human Services, in their respective testimony before this Committee, explained how the President's plan fixes what is broken and builds on what works. In the rest of my testimony, I will describe how the President's plan fixes what is broken by putting consumers first, and builds on what works to ensure access and choice. I will focus on the roles of the Federal and State governments, and the alliances, on employer and employee responsibilities, on private health insurance reforms, and on our proposals for long term care. At the continuation of this hearing tomorrow, you will hear further testimony on the financing of health care reform, our strategy for containing health care costs, the relationship of Medicare to health care reform, and new Medicare coverage for prescription drugs.

THE FEDERAL/STATE/PRIVATE SECTOR PARTNERSHIP

First, and most fundamental, the reformed health insurance system must be grounded in a Federal/State/private sector partnership. The President's philosophy is that the Federal government should establish what is guaranteed to all citizens and what is expected of our health care system. However, because health care is a local industry and a personal service, the President also believes that the federal government is not best suited to anticipate and respond to the particular circumstances

and needs of consumers and providers in each community in this country.

Because one size will not fit all, the President's plan asks each State, community and the private health care system to play a role in determining how best to provide these federal guarantees to their citizens. Individuals will also have new responsibilities. Fundamental to this Federal/State/private sector partnership is a belief that we must fix what is broken while building on what works in our current system.

FEDERAL GUARANTEES

The Basic Federal Guarantees

The Federal government, through a national health board and the other Executive Branch departments, will set overall standards for the new system. These standards will fix much of what is broken in the current system by providing for:

Universal coverage. Through shared responsibility, employers, individuals, and governments all contribute to premiums.

Guaranteed comprehensive benefits. All health plans must offer the guaranteed national benefit package. The guaranteed benefits established initially will be comprehensive enough to cover people's health care needs.

Because one size does not fit all, health plans may also offer supplemental policies.

Insurance reform. All plans must accept applicants on a first come-first served basis (unless the plan is a closed panel plan which is full). Pre-existing condition clauses, waiting-periods, and "skimming" (selection of low risk applicants) are not permitted. Community rating is required.

Standardized forms and administrative simplification. Uniform reporting requirements and standardized forms will dramatically lighten providers' paperwork burden.

Consumer protections. Health plans must provide information about their providers, their utilization control and quality assurance procedures; these must comport with Federal rules. Throughout the system consumers will be guaranteed grievance and appeals procedures that meet Federal requirements.

Quality assurance. The Federal government will develop a quality assurance system that measures the outcomes of care and that can provide this information to consumers, and practitioners to assist them in improving the quality of care.

Control of health care costs. Federal standards will govern the reorganization of private health care markets to promote competition on the basis of quality, efficiency and service. Federal rules also will assure a greater voice in the marketplace for consumers of health care. A backup system of budgets will reinforce the efficiency-enhancing and cost-savings pressures created by the reformed markets.

Improved Choice. Putting consumers first means improving choice. Today, many people must choose from the one or two plans offered by their employer. The President's plan will dramatically increase consumer choice, by expanding the number and type of coverage options available in communities.

Role of the National Health Board

A national board will be responsible for setting many of the basic Federal standards. We envision a seven-member board, appointed by and accountable to the President, which would be an Executive Branch agency. We envision a board of experts -- dedicated to the issues related to health reform -- as the policy making body. This approach allows us to draw on a breadth of expertise -- from medicine, health care financing, state systems, consumer protection, and service to vulnerable populations -- to guide evolution and change in our health care system.

Initially the board is responsible for approving each State's plan for implementing reform. It also will decide when a State is out of compliance with its plan. The board calculates premium caps; automatic adjustments in premiums are triggered when they exceed these caps. The board also will develop appropriate risk adjustment factors, to recognize legitimate patient-driven differences in costs of care between health plans.

This board will update the guaranteed benefits over time to reflect changes in health care practices, technology, and training. The national board also will establish standards of access and quality for health plans. It will develop the core quality and performance measures for a health plan performance report along with consumer survey questions. These will be updated over time.

We envision a board that acts much like a board of directors, relying on other agencies for research, leg-work, and analytic support. For example, while the board will be the decision-maker on the basic federal quality standards, HHS would contribute much of the research and analysis to support the board's functions.

Role of the Department of Health and Human Services (HHS)

HHS will play a key role in the development and oversight of the new system, in addition to its ongoing responsibilities for Medicare and Public Health Service Programs. For example, some of these functions will include:

Enforcing State compliance. We fully expect States to do what is required to provide health security for their citizens. Because health security will be federally guaranteed, however, we are obligated to provide for contingencies in the unlikely event that this would not occur. HHS will have significant responsibilities relating to monitoring of State compliance. If a State fails to establish a plan or, at some later date, falls out of compliance persistently and in ways that create a serious risk that all eligible individuals will not have access to the nationally guaranteed health benefits package, the Secretary must assume the responsibility for establishing one or more health alliances, in compliance with Federal requirements. However, States will be permitted to resume their responsibilities as soon as they are ready to do so.

Public Health Service. The Public Health Service will undertake new initiatives to reduce barriers to access and help publicly funded providers become integrated into the reformed delivery system.

Graduate Medical Education. Today, nearly 70% of physicians are specialists. HHS will play a key role in increasing the supply of generalist practitioners. Based on the recommendations of expert panels, HHS will phase-in a decrease in the number of physicians entering specialty residencies and shift the focus to primary care. Everyone will contribute to the costs of funding graduate medical education through the premium structure. These funds will be pooled and allocated based on the recommendations of experts regarding the allocation of residency positions among academic health centers.

ROLE OF THE STATES

State Flexibility

As we fix what is broken, we will also build on what works at the State level. States have a great deal of experience in many of the nuts-and-bolts aspects of health system oversight, such as licensure of health care providers and regulation of the health insurance industry. In addition, in recent years States have made significant strides toward health reforms.

Each State will develop an implementation plan. This plan must describe how the State will perform the following broad functions:

- * Provide universal enrollment.
- * Provide for a system for collection of premiums.

- * Implement insurance reforms, including mandatory open enrollment, guaranteed renewability, and community rating, and financial standards for health plans.
- * Certify health plans.
- * Provide for administration of data collection and quality management programs.

States must designate an agency or official to coordinate these State responsibilities. Within these broad parameters, States remain free to exercise significant flexibility. States may establish alliances and provide for their boundaries, governance, and operations, subject to federal guidelines. Alternatively, States may also choose a single payer framework in which all providers are paid directly by the State, or an all-payer framework in which providers are paid common payment rates by all insurers. A State electing a single payer approach may require all employers and individuals in the State to participate in the single payer system.

The State/Federal Medicaid program will purchase health coverage in the alliance for its enrollees on cash assistance. A maintenance of effort of State Medicaid spending for current non-cash assistance enrollees will be required. Beneficiaries will no longer be restricted to the few providers who choose to accept them. They will be mainstream members of their local alliance,

and will have choice of health plans available through that alliance. Medicaid will fully discount its beneficiaries' choice of plans up to the average-cost plan in an alliance. Additional discounts will reduce their cost sharing by 80% in low-cost sharing plans.

Role of the Health Alliances

Putting consumers in charge means improving their ability to negotiate effectively with health plans. The President's plan resolves the current fragmentation of demand by aggregating the purchasing power of individuals and groups into large buying pools called alliances. Only employer and consumer representatives may serve on an alliance board of directors. Each alliance will represent all people within their borders. Alliances are not regulatory agencies. They will follow Federal and State rules to promote the interests of the consumers they represent.

Alliances will be responsible for enrolling all individuals in their area into health plans. In so doing, alliance will re-establish community risk pools, providing a stable actuarial base for community rating premiums. Alliances will make available to consumers information on health plan features, and will administer subsidy systems. Alliances will have important quality monitoring functions, including oversight of consumer satisfaction and disenrollment rates for health plans.

Any health plan that wants to operate in an area must do so through the health alliance; the alliance then makes all such plans available to its members. In order to obtain the best premiums for their members, alliances will solicit competitive bids from insurers and make sure that premium do not exceed the overall cap. Competitive pressures and incentives will induce plans to offer high quality service at affordable premiums in order to get and retain membership.

Grouping purchasers into alliances can eliminate much of the overhead small employers now experience with insurance coverage. Employers will be relieved of their growing health benefits administration burdens.

Putting consumers first also means making coverage choices easy to understand. The President's plan requires each health plan to offer the nationally guaranteed benefits package. With standard benefits and the comparative performance report information available from their alliances, consumers can meaningfully compare plan quality and costs, and choose the type of plan, providers and premium structure which best meet their needs.

Finally, putting consumers first means ensuring health coverage and access to care. Alliances will be required to serve every individual in their borders. They will be under the

affirmative obligation to ensure coverage and protect against discrimination. Finally, alliances have authority to use financial incentives to encourage health plans to expand into underserved areas, and may assist providers in creating new plans in underserved areas.

PRIVATE SECTOR RESPONSIBILITIES

Role of Employers

All employers will contribute to the purchase of health care coverage for their employees by paying at least 80% of the weighted-average premium for health insurance coverage in their health alliances or in their corporate alliance. The required contribution for employers in the health alliance will be capped at 7.9% of payroll. Additional discounts will be available on a sliding-scale to small, low-wage employers with less than 75 employees. Those with the lowest wages will be able to purchase insurance for 3.5% of payroll. The self-employed will be able to deduct 100% of their health expenses.

Role of Corporate Alliances

Employers of sufficient size (as well as Taft-Hartley plans and rural electric cooperatives) will continue to have the option of self-insuring their employees' health benefits by forming a corporate alliance. Any private employer with over 5000 full time employees nationwide may elect to form a corporate alliance.

These large employers may also, of course, participate in the health alliance.

A corporate alliance will serve the same functions as a health alliance, under similar requirements. (ERISA is amended accordingly.) Corporate alliances must offer health plans that provide the nationally guaranteed comprehensive benefits. Each corporate alliance must hold an annual open enrollment, and provide comparative information about health plans. Grievance procedures and reporting requirements applicable to health alliances also apply to corporate alliances, as do administrative simplification mandates. Each corporate alliance must offer at least one fee-for-service plan and at least two other plans (with waivers for areas where such plans are not available). Corporate alliance plans must accept all eligible enrollees on a first-come first-served basis and may not terminate enrollees or limit coverage for the nationally guaranteed comprehensive benefit package. Exclusions for pre-existing conditions and waiting periods are prohibited.

Finally, plan premiums in the corporate alliances must stay within the nationally established target.

A corporate alliance makes premium payments directly to health plans, using any type of insurance rating arrangement. In addition, corporate alliances will be required to pay a surcharge

to help support the infrastructure of health care, such as financing the cost of medical training and research in academic health centers, that will be otherwise supported by premiums in the health alliance. Employers that form a corporate alliance will periodically have the opportunity to switch to the health alliance. For self-insuring employers which join the health alliances, community rating and discounts will be phased in over eight years.

Together, the system of health and corporate alliances will reform markets so that health plans will have to compete for consumers on the basis of quality and efficiency. Reorganizing markets in this way will create new incentives for providers to develop innovative approaches to management of acute and chronic conditions.

Role of the Individual

Let me emphasize: every person will choose his or her own doctor and health plan. No employer, no government, no bureaucrat will make these decisions for us.

After the employer pays its share, families and individuals will be responsible for the remainder of the premium for the health plan of their choice. For the "family" share of premium, Federal discounts will be available for people with incomes up to 150% of the Federal poverty level. In addition, for persons with

incomes between, 150% of poverty and \$40,000, a further cap of 3.9 percent of income will limit the family share of the premium. Some people (such as, the self employed and the unemployed) may also be responsible for a portion of the "employer" share of premium. Federal subsidies for this share of the premium will be extended to those with nonwage income up to 250% of the Federal poverty level. Thus, the nation's 37 million uninsured individuals and families, 85% of whom are working people and their families, will be able to afford insurance and will be asked to pay their fair share.

Along with choice must come responsibility. Under the President's plan, we will all bear more responsibility for our health care decisions. Consumers will be required to enroll in a health plan, and will be responsible for making informed enrollment decisions that best meet their health care needs. Consumers also will be financially responsible for the choices they make; those who choose plans with above average premiums may bear the additional costs themselves.

Role of Health Plans

Health plans will provide health insurance coverage, much as insurance companies and HMOs provide such coverage today. A health plan can be a fee-for-service plan like today's indemnity plans, an HMO, a PPO or other type of network, or any other arrangement that meets the federal and State requirements. There

must be at least one fee-for-service plan available in each alliance.

Each health plan provides to the alliance information concerning its costs, the qualifications of its providers, its utilization management and quality assurance procedures, and its consumer grievance procedures. The alliance then makes this information available to consumers.

Health plans (other than fee-for-service plans) will have flexibility in structuring their relationships with providers, and providers, themselves, will be encouraged to form new health plans. Health plans will be required to contract with Essential Community Providers during a transition period and pay them no less than rates paid to other providers in the community, or pay them based on Medicare reimbursement principles.

LONG-TERM CARE

Why We Need Reform

Throughout our health care reform deliberations, the President, the First Lady, and the Secretary have been unwavering in their commitment to include long term care as part of the health care plan. They are deeply concerned that many people of all ages with chronic disabilities lack the supportive services they need to lead independent lives at home, in their own

communities:

* There are millions of American families who face the challenge of providing long term care virtually without help. As our nation ages, we believe these informal care givers, the backbone of our nation's long term care system, need reinforcement.

* For most people the only way to obtain public assistance with long term care is first to exhaust all their financial resources in order to qualify for coverage through the welfare-based Medicaid program. Even then, access to home and community-based care may still be very limited, depending upon where a person lives.

* Talented and capable adults with disabilities are unemployed because they cannot afford the services they need to permit them to go to work.

The Administration is equally concerned that people who want to insure themselves privately against the risk of long term care are too often unable to find high quality, affordable policies on which they can depend.

What The President's Plan Offers

The President's plan offers a package of long-term care

reforms that will help mend the current system and that will address the diverse needs of people with disabilities, regardless of age. The focal point of this reform is a major expansion of home and community-based care services through the establishment of a new federal/State program targeted to people with severe disabilities, regardless of age or income. The federal contribution -- at a much higher match rate than in the current Medicaid program -- will provide incentives for substantial expansion of these services, but will be capped to control costs and ensure predictable growth. Beneficiaries with incomes above 150% of the federal poverty level will be asked to share the cost of their care, according to their ability to pay.

This plan recognizes that many States, after years of struggling with the long-term care dilemma, have successfully developed innovative and creative home and community-based/personal assistance programs. This new program builds on this wealth of State experience by allowing States wide flexibility to design and implement programs appropriate to their particular needs and characteristics. At the same time, to ensure equitable access to services and consumer protection across States, the federal government will prescribe uniform eligibility criteria and require States to develop consumer-oriented services and quality assurance arrangements.

In addition to the expansion of home and community-based

care, the plan liberalizes Medicaid nursing home requirements by raising the monthly personal needs allowance and increasing the asset protection level. We will also provide a tax credit for working people with disabilities to defray some of the costs of the personal assistance services that allow them to remain employed and productive.

Finally, the President's plan establishes federal standards for private long-term care insurance, with State implementation and enforcement, and provides grants to the States to enhance their consumer education activities. It also provides tax incentives for the purchase of private long-term care insurance.

This package of benefits, when fully implemented, is expected to provide immediate assistance to about three million people with severe disabilities living in the community and two million residents of nursing homes and other institutions. In addition, the steps we are taking to improve the private long-term care insurance market will raise the confidence of all Americans that high quality policies are available and will pay off when the need arises.

CONCLUSION

Mr. Chairman, there is room for debate about the details of this plan. But the basic principles are not open to compromise:

- * All Americans must be guaranteed a comprehensive package of benefits that can never be taken away.
- * Everyone must make a contribution.
- * Health care quality must be preserved and improved.
- * Consumers' choice and access to care must be enhanced.
- * The rate of growth in health care costs must be slowed.
- * Administrative requirements and costs must be streamlined.

It also is important that States have continued and enhanced flexibility to pursue health care system improvements. Within basic federal parameters for universal coverage, affordability, and quality, each State should be able to design the system most responsive to the needs of its people.

First Year of Clinton Plan
Health Alliance I

Plan A

Plan B

Plan C

Premium = \$2,000 Premium = \$3,000 Premium = \$4,000

Weighted Average Premium Calculation

$2(\$2,000) = \$4,000$
 $2(\$3,000) = \$6,000$
 $2(\$4,000) = \$8,000$
\$18,000

Weighted Average Premium for Alliance = $\frac{\$18,000}{6} = \$3,000$

2d Year: Plans are so cost effective, they freeze their premiums at 1st year levels

Plan A

Plan B

Plan C

Premium = \$2,000 Premium = \$3,000 Premium = \$4,000

Weighted Average Premium Calculation

$1(\$2,000) = \$2,000$
 $1(\$3,000) = \$3,000$
 $4(\$4,000) = \$16,000$
\$21,000

Weighted Average Premium for Alliance = $\frac{\$21,000}{6} = \$3,500$

Update for 2d Year Budget

Alliance: Update allowed for premium cap = 5.2%
 Update premium = (5.2%)(\\$3,000) = \\$151
 Permissible weighted average premium = \\$3,151
 (Premium cap from 9/7/93 draft)

Budget Compliance Calculation

Allowed weighted average premium = \\$3,151
 per person
 Actual weighted average premium = \\$3,500
 based on individual choice

Amount Exceeding Budget, per person = \$349

STOP

Mr. WAXMAN. Thank you very much, Dr. Feder. I would like to start the questioning myself.

Under the President's plan, there are subsidies for low-income people and for small businesses and for retirees. These subsidies are to protect people so that they only have to pay a certain amount of money and they are assured coverage.

For fiscal year 1996, the subsidies can't exceed \$10.3 billion. Over the first 5 years of the plan, they may not exceed \$274 billion. Now, I know that this number is a result of your best estimates about how much money will be needed to assure that comprehensive coverage is affordable to those who are depending on this help, and I understand you are also—you have also increased these estimates to include a cushion of 15 percent to provide a margin of error. However, in the end, the estimates may be wrong.

My question is: What happens if this fund comes up short? Secretary Bentsen testified here last week and he was asked that same question, and he said that Congress would do the right thing, that Congress and the President would increase the amount of money in the fund so that it wouldn't run out of money.

I have a lot of respect for Secretary Bentsen's judgment, but what if he is wrong and an effort to increase the subsidies fail to get 60 votes in the Senate? Who is left holding the bag? Is it the State, the alliance, the health plans, the hospitals, physicians, or the early retirees, small businesses, and low-income people?

Ms. FEDER. Mr. Chairman, you have gone through the mechanisms that we have included in the plan to ensure that that cap is never breached. And we feel that that is a critical element of the plan, the conservatism of our premium estimates, the cushion which includes an estimation of what happens if there is a major recession in this country, which of course we expect not to happen but should it happen—the cushion includes room in case there is a 2 percentage point increase in unemployment.

Mr. WAXMAN. I know all the things you have done to assure you that you think you have got the estimates accurate. But what if you are wrong?

Ms. FEDER. As Secretary Bentsen indicated, we have a mechanism whereby the President goes to the Congress with a set of recommendations. The Congress acts in an expedited fashion, and in answer to your question, all of us, essentially, all citizens in this country in the health care system have a stake at that point in seeing that Congress and the President do indeed do the right thing because the system requires that that action occur.

Mr. WAXMAN. And if the Congress doesn't act, what happens?

Ms. FEDER. Essentially I would argue, Mr. Chairman, that the Congress has to act in order for the system to continue to be responsive to all of us as citizens. There is no particular segment of society or particular entity that is then at risk. Essentially in order to provide for the continued operation of the health care system, action is essential.

Mr. WAXMAN. And if action is not taken, does the whole system come to a halt?

Ms. FEDER. Well, I think that action would be taken. I recall in 1983, as I am sure you recall better than I, when there was a concern about the Social Security checks getting out, that our Social

Security system needed help from Congress, and the problems in it were addressed. I think that it is a responsibility of all of us as public officials to ensure the accountability and the stability of a system on which all Americans depend.

Mr. WAXMAN. Now, under this plan, it seems likely that most alliances will be collecting and disbursing large amounts of private and public funds, amounts that in many cases will exceed several hundred millions of dollars a year. For many States, this sum could exceed their entire budget.

Could you describe for us the protections in the bill to assure the prudent and responsible management of these funds? Who is at risk if the funds are mismanaged or illegally diverted?

Ms. FEDER. Essentially the Secretary of HHS is responsible for setting the standards, I believe, in consultation with the Secretary of Labor or Treasury for the alliance operations. The alliance—the arrangements are such that the holding of funds by alliances is not the case. And the standards will be made explicit in regulations.

You ask about the case if the funds are abused. Essentially, States are held accountable for the integrity of the operation of the alliances.

Mr. WAXMAN. There has been a lot of discussion about the appropriate size of Health Alliances. One of our next witnesses argues that smaller alliances incorporating employers of 750 to 1,000 workers would be sufficient to guarantee access to coverage in the small employer market. At the other end of the spectrum, some have advocated that everyone, including large employers with more than 5,000 workers, purchase health coverage through a regional alliance. The President recommended, including all employers with less than 5,000 workers in a regional alliance.

My question is: How did you arrive at that number and what do you think would happen if we reduce the employer size to, say, 1,000 or 750?

Ms. FEDER. Well, we too heard the different points of view as we deliberated the structure of this plan, Mr. Chairman, and what we have tried to do is to strike a balance. Our concern in determining the size of the pool is to recreate a true community for health insurance in which risks are truly shared, and to maximize individuals' opportunity to choose their plans, rather than having employers choose.

At the same time, we recognize that certain very large firms, most of whom are multistate, would find it easier to operate in their own plans and we wanted to continue to provide them that leeway. It is also among these largest plans that we have seen innovation in the operation of insurance and in our health care delivery system. And that—this arrangement allows the flexibility to continue to have that kind of variation in the system.

As we look at or as people propose changes in the size, it is our concern that we continue to keep a broad community and retain essentially the risk allocation that we feel is so vital to having the system function effectively.

Mr. WAXMAN. Our last panel of witnesses this morning representing the health insurance agents will testify that under the President's plan, requiring all health plans to be offered through an alliance is anti-competitive. They argue that people should be able

to buy insurance either through an alliance or directly from plans or their agents. They believe that such a system can work fairly if the rules are the same for plans offered inside or outside of an alliance.

Obviously the President has come to a different conclusion. Your bill requires alliances to be the exclusive means for obtaining health coverage except for large employers. What do you think would be the result of permitting a reformed private insurance market to compete for business with the plans offered by alliances?

Is it possible to apply a risk adjustment to plans outside of an alliance to keep them from selecting only the healthiest people?

Ms. FEDER. Well, again, we too have heard those proposals and the primary source of pressure for changes in the alliance structure does seem to be coming from the insurance industry. Our concern in this regard, again, is that even though new rules for health plans can be very effective in making improvements in our current marketplace, we need to have, as I indicated earlier, as large a pool as possible in which individuals are selecting their plans in an objective fashion, in which they are—through information provided by an objective third party—able to make the choices, and there is not then an opportunity for selective marketing that allows discrimination.

And we would be concerned about a departure from that model that might, even with risk adjusters, allow the kind of discriminating marketing that pulls the system apart.

Mr. WAXMAN. Well, even if you have one alliance and everybody's in it, why wouldn't some plans try to market themselves through to certain select groups of people who would be better risks?

Ms. FEDER. Well, what the alliance does for you, for all of us, is create a centralized enrollment process in which individuals are choosing based on information that the alliance provides and oversees to its consumers. There is very little opportunity in that arrangement to have the kinds of aggressive marketing that leads to discrimination that we see today. And so we think that is a major assistance in the creation of alliances.

Mr. WAXMAN. Now, there could be a possibility of redlining an area for an alliance and there are ways to stop that in this legislation. You have to take a statistical area and you can't try to gerrymander these alliance areas. But within an alliance, can they—can plans select out only a portion of the area within an alliance is served?

Ms. FEDER. Well, we have plans certainly as we develop HMO's which may have a limited network, whom they prefer or choose to serve a selected area. And that may raise some concerns about discrimination. That is why we have included authority at the State level that would enable the State to direct plans to serve either the whole alliance, if that were appropriate, or selected areas if there was a concern about discrimination.

Mr. WAXMAN. Thank you. I am going to recognize each member for 10 minutes, starting with Mr. Stearns.

Mr. STEARNS. Thank you, Mr. Chairman.

And I want to welcome you, Dr. Feder. You indicated, I think, that this is almost a nonpartisan issue, because the chairman has touched on something I think the Minority is concerned about and

that is insolvency. I have heard you use a term a number of times, Congress will do the right thing, Congress should do the right thing, Congress could do the right thing, and that the administration, the President is going to do that.

Now, I served 4 years on the Banking Committee. It is awfully hard to get funding for RTC, awfully hard to get funding for S&L. So I think the questions the chairman brought into you is something the administration should look carefully at.

I have two charts here I want to take you through. We looked at your September 7th draft. It appeared that the September 7th draft, in the draft the alliance was given the authority to limit the number of fee-for-service plans to three, but that restriction appears to have been dropped.

Ms. FEDER. That is correct.

Mr. STEARNS. I continue to have serious doubts about the extent of choice provided in your plan and I think that is an area you and I have some concern, particularly choice if a person wants more comprehensive, in other words shall we say more expensive fee-for-service plan that gives more services, more freedom, choice of doctor.

When you look at how the plan actually operates, you realize that choice is limited. So let me just take you through this graph on the left which is a little hard to see, so I would—what I would like the staff to do is take what we have is a little—could we give the—I think you have that.

Ms. FEDER. Yes, thank you, sir.

Mr. STEARNS. Well, without reading, going through, you have three separate plans in a—we will call it Health Care Alliance 1. And just for the sake of simplicity, you have two employees in each of the plans, and what their premium costs are and they have taken that, \$2,000, \$3,000, \$4,000, and they came up with a weighted average premium for the alliance, which is the top \$3,000.

Now, the reason I want to go through this, I want to show the implications of your plan in the second year if the weighted average premium changes, which it does. Now, let's say plan A is pretty much the similar, plan B is the same, but plan C, you and I are in plan C and our families, and we want to increase the comprehensive plan. We want to—it is a more expensive plan, we have a whole set of things we want additional. So it is going to cost more obviously. So we go ahead and put that in.

Well, if you take the three plans, plan A, B, and C, and then you bring the weighted average premiums for the alliance, it comes up to \$3,500. So the first year it is \$3,000, the second year it is \$3,500.

Now, let's assume that this is brought to the attention of the administration and at this point, the alliance has a very big problem because the average weighted premium is substantially greater than the alliance premium target. You talk about only 5.2 percent increase.

Well, as you can see from this chart, we are going up much more than 5.2 percent. Which means that the weighted average premium in year 2 can be no more than \$3,151, if we took the 5.2 percent of the \$3,000.

At this point, the alliance would be out of the compliance of the Federal law because our weighted average premium achieved only by individuals choosing different plans, using your word, that person chooses a different plan, it is more comprehensive, more expensive, it is \$3,500. Therefore, for every individual in the alliance, the premium target has been exceeded by \$349.

And again, let me emphasize that this has occurred even though every plan froze their premiums in the second year, which is not going to happen, you know. Consequently, a serious violation of the statutory premium cap has occurred because citizens exercise their freedom to choose.

So my question is: Is the intention of the President's plan to operate in this manner—it is almost a bizarre manner in which a person has a choice—when they make the choice, the weighted average goes higher and then it is above the 5.2 percent?

The second part of that question is: Under the President's plan, what does the alliance do so that it is in compliance with the plan? Does it go back to individuals and say, oh, no, you can't have that more comprehensive, more expensive plan, and can you please point us to the section numbers in the bill that explain this, because we have had trouble understanding it?

Ms. FEDER. OK. Mr. Stearns, you have mentioned several times, talked about the individual's choice and choosing a more comprehensive plan. And I think that a clearer articulation of the President's plan will alleviate some of the concerns that you have raised. Essentially, we are looking at a new system in which every plan is offering the same benefit package, the guaranteed comprehensive set of benefit, and doing so under community rating. So all plans are equally comprehensive, and all plans are similar in the benefits they provide and the rating structures they use. So the example you have put forward, we would argue, is potentially quite misleading in terms of the range of premium variation that you have on the chart.

Essentially, you have the plan C, the high cost plan, being double the cost of plan A. Given the nature of the marketplace changes, we are proposing and are critical to the plan design, we would not expect to see that kind of variation in the marketplace.

Mr. STEARNS. Will you just defer? One, the plan C is fee-for-service.

Ms. FEDER. Regardless.

Mr. STEARNS. In other words, that person has a rate to choose that.

Ms. FEDER. Absolutely.

Mr. STEARNS. And you said that, the administration has said that. So really that person has made that choice to go fee-for-service.

Ms. FEDER. But I am not questioning the choices, you are absolutely correct. In fact, we have enhanced the access to fee-for-service plans in our draft legislation. The question that we are raising, though, is the fee—the premium range on all plans, whether they are fee-for-service or HMO's, essentially are going to be bidding in the same marketplace, and we believe they are provided and have the capacity to operate within the premiums we are estimating and

that is why it is that we think the range will be far narrower than you put forward. There is another element——

Mr. STEARNS. You say it is narrower.

Ms. FEDER. I was going to go, if I may, to another point. If you will also recall, as I indicated in my opening remarks, that an alliance may reject a plan whose premiums exceed 20 percent of the average. So in order to guarantee choice to the consumers, affordable choice, the alliance has the capacity explicitly to limit the range of premiums that a consumer is facing.

Again, we think that variation is important because there are differences in the style of plan operations, but we also think it is important that we not exaggerate the range of variation that is likely to occur.

Mr. STEARNS. But isn't the example we have pretty much illustrative of what could happen, a person in the second year decides they don't want to go the standard, they want to go fee-for-service? And isn't it possible then, the second year, you are going to be out of—the weighted average is going to be above 5.2 percent?

So I think you have to address the real possibility that the second year is going to be above the 5.2 percent, and what are you going to do because this person has made their choice?

Ms. FEDER. I guess I would like to continue. I think it is really important that we consider how this is going to operate in the real world, and I think it is useful to go through the example so that we can all think through how people are likely to behave and what we are going to achieve.

Mr. STEARNS. Just use my example if you could.

Ms. FEDER. I am. I wanted to go to the next piece of it. So first we would argue that we have to do a new example in which the range was far narrower. The second piece is what happened, what movement we are likely to expect of people across plans. Essentially, the evidence from the alliances that we have is that movement is relatively limited across plans, and there is very little reason to expect that movement would go only to the highest cost plan. In fact, I believe we have some evidence, and I will double-check for you, that there is some movement, if there is some movements it is in the direction of lower cost plans.

And so the whole scenario you put forward here does not seem consistent with any evidence we have about consumer behavior in the marketplace, so we would question whether this outcome would occur.

Mr. STEARNS. The word "movement" is a key term here. Don't you agree, though, that movement is likely in some years to go higher, that the weighted average is going to be high because people make choices towards the fee-for-service?

Ms. FEDER. No, we actually——

Mr. STEARNS. If that is true, I don't see how you could take the example as bad, because this whole idea of movement is based upon consumer choice and a lot of the consumers, if years go on—they decide "I didn't like that standard package; I want a little bit more." They are going to go fee-for-service with more money and you are going to be out of this 5.2 percent. I think what you have to address is what is going to happen if you are out of the 5.2 percent.

Ms. FEDER. Let me just——

Mr. STEARNS. I think that goes a little bit to what the chairman's question was. You are going to have to come in with some regulation to stipulate.

Ms. FEDER. I want to reemphasize this is not a question of comprehensiveness. The comprehensiveness is guaranteed; nor do we necessarily have reason to believe that the fee-for-service will be the most expensive plan. There are mechanisms in this plan that would allow fee-for-service plans, indeed require them to operate far more efficiently than they operate in the current system, so I would again question your assumptions.

And with respect to the mechanisms, should these occur, we have very clear mechanisms in the bill that lay out what happens to premiums when the weighted average is exceeded and we would provide you the citations for the record.

Mr. STEARNS. Mr. Chairman, my time has elapsed. I just ask Dr. Feder to give us the section number in the bill that the question was asked about early on.

Ms. FEDER. I prefer to provide it for you for the record. If you need the staff to find it now, we could do that as well.

Mr. WAXMAN. Let's get it for the record and give it after the hearings.

[The following references were provided:]

The language referred to was contained in Sections 6003, 6004, and 6005 of H.R. 3600, the proposed health care reform bill.

Mr. WAXMAN. I am pleased now to call upon my Cochairman of this hearing, the distinguished gentlelady from the State of Illinois, Mrs. Collins.

Mrs. COLLINS. Let me apologize for not being here for your entire testimony, but unfortunately I had to be at my ophthalmologist this morning and wouldn't cancel my appointment.

In light of the States' roles in regulating and certifying health plans, I would like to know what would happen if a certified health plan went out of compliance for a sustained period of time; I want to know whether or not it would be decertified. If decertified, would that plan be required to drop out of the alliance market and, if so, what would be the alliance's options and responsibility with regard to the enrollees of that particular health plan?

Ms. FEDER. Essentially, with respect to the certification of plans, the State would have to recertify it before it could operate again if that is your question.

Mrs. COLLINS. So then the people who are enrolled in that plan would be out of luck?

Ms. FEDER. Anytime a plan is not operating effectively, there are mechanisms for guaranteeing the availability of services to the enrollees and payment to providers for their services. There is always a fall-back mechanism.

Mrs. COLLINS. Who would provide those services if the plan were knocked out?

Ms. FEDER. Actually, I would turn to Mr. Claxton.

Mrs. COLLINS. Mr. Claxton.

Mr. CLAXTON. There are a couple of things that happen here. If the plan is decertified because it is not providing quality services

or it otherwise fails to meet the conditions for certification, individuals would be given a choice to enroll in another health plan.

If the health plan failed financially, individuals would be given again a choice to enroll in other health plans. During the period of time between the time the plan fails and their ability to enroll in new health plans, providers would continue to provide services to them and those providers would be paid through a State guarantee fund mechanism.

Mrs. COLLINS. Well, I want to ask some more questions about this premium pricing. I would like for you, Dr. Feder, to describe to me the process by which you expect the Health Alliances to engage in the price negotiations with the providers in the health plans and whether the process would coincide with or conflict with the premium limitations that the bill is going to impose?

Ms. FEDER. Essentially we are relying, Mrs. Collins, on a bidding system to determine the premiums so that plans who have been certified and will meet the requirements of providing the guaranteed benefit package and the other requirements would bid to the alliance for the opportunity to serve the community that is in the alliance.

The alliance would also be provided by the national board with a premium target or cap as we discussed earlier for the weighted average premiums.

Now, it is our expectation that as plans bid, their concern will be to attract consumers in this alliance and that they will have a strong incentive to keep their prices down for quality service to get people to choose their plan. And so it is our expectation that the premium cap is essentially a fail-safe or a backstop mechanism. But it is there in order to guarantee the affordability of premiums.

And if the bids come in in such a way as to put the alliance over the average, over the cap, then the alliance has the opportunity to go back to the plans and ask them to resubmit their bids, again giving them an opportunity to reconsider what is happening in the marketplace and to come in more consistently with the cost containment backstop provided in the bill.

Should they not do so, we have a mechanism—and in fact, then the premium cap would in that case be breached by the alliance, the Board would make a judgment that the premium cap had been exceeded, and then there is an automatic mechanism for adjusting the premiums and provider payments in plans that have exceeded that cap to ensure that the cost containment objectives in the system are achieved.

Mrs. COLLINS. It is my understanding, and correct me if I am wrong, that some States would have the option of using the single-payer plan if they chose to do so. What mechanism would there be to keep costs down for the States who use the single-payer plan?

Would their costs or the amount of money, the funding with which they could use for a single payer plan, be based upon some kind of percentage of what the other alliances would have to work with or how would that work?

Ms. FEDER. Well, they would be subject to the same constraints in terms of costs as the other States would be. They would be entitled to subsidies consistent with what other States receive and they are able to rely on a financing mechanism of their choosing as long

as it is in part payroll based and would not create incentives—would not reduce burdens on employers such that you would see a competition for employment across State lines. And they have the full array of mechanisms available to them for keeping the costs under control.

Mrs. COLLINS. In order to have a single-payer plan, would a State have to conform to some basic structure that is pretty akin in some way to the alliance structure?

Ms. FEDER. Not to the alliance structure but essentially to the guarantees that the plan would provide all citizens.

Mrs. COLLINS. OK. I would like to know what role the Health Alliances will serve in providing an efficient health care infrastructure in medically underserved areas and ensuring that the health plans will provide adequate services and provide networks in those areas.

What I am really trying to get at is what is the enforcement mechanism to protect those underserved areas or areas that might be medically underserved?

Ms. FEDER. Now, the enforcement mechanism essentially falls to the State. It is the obligation of the State to see that there are plans available to all of the citizens in the State in all areas. The alliance can be a facilitator in that process by assisting in the development of plans in underserved areas, by providing financial incentives for plans in those areas, so again consistent with its role as assisting and operating, acting for consumers, it could operate in that way.

Mrs. COLLINS. Well, it is my understanding that the administration has been making the point that alliances are not going to be in any way regulating the health plan. Is that not the case? Am I incorrect in that?

Ms. FEDER. It is the State that is the regulator. I guess I was trying to distinguish to clarify that role in my answer.

Mrs. COLLINS. OK. I just want to make sure I am understanding what I am getting an answer for here.

The bill indicates that a company with over 5,000 employees could choose to place all or some of its small establishments in the appropriate regional alliance while providing health coverage for the rest of the employees through a corporate alliance. Yet, if a company could choose to place only some establishments in the regional alliances, wouldn't this create an adverse selection problem whereby the company could share the burden of only their highest risk officers and employees?

Ms. FEDER. The opportunity to choose selectively is quite limited. It is limited to establishments with 100 employees and is included to recognize the fact that even the very large corporations may have parts of their operations with very few employees. So to make it easier for them and better for the employees we have given them the opportunity to go into the regional alliance. So we don't see much risk to that provision and we think it enhances flexibility.

Mrs. COLLINS. In light of the greater power that health plans are going to have in the new system, due to their increased market share, I think consumers need increased protection when they believe that their insurer has acted improperly, such as when a health plan refuses to pay for a treatment that has been prescribed

by a doctor. Although you have proposed an ombudsman within each Health Alliance as an impartial party to resolve these disputes, I am concerned that there may not be adequate numbers of ombudsmen in order to resolve these disputes.

Have you considered other mechanisms for resolving disputes between the consumer and the health plans?

Ms. FEDER. I think that we share your concern with consumer protections and with holding plans accountable. I think it is one of the critical differences we see from the current marketplace in which plans are not held accountable for their service for consumers.

The ombudsman is a mechanism that we think is part and parcel of that, providing consumers assistance along with grievance procedures within plans. We also have established in the bill, a mechanism for a grievance procedure beyond the alliance.

Mrs. COLLINS. Could you tell me what those would be?

Ms. FEDER. The State establishes a grievance procedure and that involves an administrative procedure operated at the State level, and that goes up to, I believe, a Federal dispute board as well. So there is an extensive grievance procedure in the bill.

Mrs. COLLINS. So the procedure would be to start one with the State and then go to the Federal and then the ombudsman?

Ms. FEDER. I think we should try for other than a Swedish term in this.

Mrs. COLLINS. I do, too.

Ms. FEDER. The ombudsman is essentially there to help a consumer negotiate if they are having difficulties. They do not have power to act—to require their assistance, so aside from their assistance, one needs formal grievance procedures and I believe I have articulated them correctly. If not, I will double-check and provide it for the record.

Mrs. COLLINS. Thank you.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Mrs. Collins.

Mr. McMillan.

Mr. MCMILLAN. Thank you, Mr. Chairman.

Dr. Feder, as I pointed out in my opening remarks, during our hearing with Mrs. Clinton she assured us that the committee would be provided with all the work product and quantitative analysis that went into developing this bill. When Secretary Shalala testified, she promised that information would be made available as soon as the administration's proposal was released.

And Secretary Bentsen, in the hearing last week in pointing out the administration had consulted the best experts in the country with respect to actuarial assumptions and costs analyses—they certainly are a part of your thinking—and agreed also to supply that information, and again, we have yet to receive anything.

When will this information be made available to this committee?

Ms. FEDER. Congressman, we are, as you indicated, testifying before you tomorrow and we will do the best to respond to your questions to the best of our ability. I believe those materials are now being fully prepared. I do not—I don't know whether anyone on the staff has the exact date of the full release, but I know they are

under preparation. Following this hearing, I would be happy to call and let you know what the plan is.

Mr. McMILLAN. That is encouraging, and we will have further discussion about that tomorrow.

Ms. FEDER. Like I said, we will to the best of our ability. I know we will have a full discussion.

Mr. McMILLAN. Thank you. In your judgment, just to get this in perspective, how many regional alliances do you anticipate there being created under this legislation?

Ms. FEDER. We would expect about 100, Congressman.

Mr. McMILLAN. Does that mean two per State or four in New York and one in Rhode Island?

Ms. FEDER. There will certainly be differences across States because there will likely be more alliances in very heavily populated States.

Mr. McMILLAN. Those alliances basically have to be approved by the National Health Care Board.

Ms. FEDER. The State plan is approved by the Health Board and the alliances are part of that plan.

Mr. McMILLAN. So North Carolina could come up and say we want to have six regional alliances.

Ms. FEDER. It could.

Mr. McMILLAN. You would take that under advisement.

Ms. FEDER. There, I think again our concern in the establishment of the alliances, as indicated in the bill, is that they be broad enough pools to enable plans to have a broad pool of enrollment and with those certifications and the other specifications, the Board would entertain the plan.

Mr. McMILLAN. Given the complex nature of setting up a regional alliance in a State, a State is likely to opt for as few as possible.

Ms. FEDER. I think it will vary from State to State.

Mr. McMILLAN. How many corporate alliances do you think will be in existence?

Ms. FEDER. Gary, do you have the number of employees?

Mr. McMILLAN. If I could preface that with one further remark, it is my understanding—and I would be interested in yours—that approximately 88 percent of the work force works for entities, businesses, institutions, et cetera, that are less than 5,000 employees, so essentially 88 percent of the work force plus the unemployed or any other beneficiaries of Federal or State assistance would automatically fall under the regional alliances?

Ms. FEDER. I think—go ahead, Gary.

Mr. CLAXTON. It is my best recollection that about 1,100 or 1,200 entities would be able to be corporate alliances.

Mr. McMILLAN. 1,100 to 1,200. And can you give me an estimate as to how many of those would opt to remain corporate alliances or opt for—

Mr. CLAXTON. I believe we made some estimates. I am not aware of what they are. I am sure that will be part of the information that we get to you.

Mr. McMILLAN. Admittedly that is a little bit of an unknown, but that is certainly going to be a moving target in terms of cost considerations because there are a lot of things built into this bill that

are accorded to corporate alliances or those in excess of 5,000 employees that are not available to others.

Ms. FEDER. Well, I think that you are quite right that we need to be clear about or have estimates as to who is likely to choose and who is not, and I believe those are included in the estimates and we can pursue those further tomorrow.

Mr. MCMILLAN. Dr. Feder, let me pursue the line of questioning a little further that I think the chairman introduced and others have touched on but put it in a little different context.

I would like to appoint you, for the sake of discussion, as the CEO or whatever we are going to call it of a State health care alliance, and let's assume it is for that whole State, let's assume it is a State that operates under a balanced budget amendment such as North Carolina or the President's home State of Arkansas, and on September 1st of the first year of implementation of the President's plan, you get a call from Secretary Bentsen telling you that the Federal Government has reached its capped amount of Federal alliance payments for subsidies for the year and Congress has categorically refused to raise the cap.

In other words, there is no more money for the last quarter of the year, based upon a capitated system established by the National Health Care Board. The Secretary tells you that although the Federal Government owes you, your alliance, \$10 million in subsidies for low-income families and small businesses. It cannot send the money because the Treasury's cap entitlement fund is broke for the year. He greatly sympathizes with your plight but it is your problem, consequently the \$10 million shortfall is your alliance's headache.

Now, according to the bill, everyone in your alliance is guaranteed—has guaranteed to the defined benefits package. You cannot drop any individual from the alliance. You cannot cut back on benefits.

Would you tell me what you propose to do for the balance of the year?

Ms. FEDER. I would immediately call you, Congressman, and make certain that you acted on what I——

Mr. MCMILLAN. I have already categorically refused to vote further.

Ms. FEDER [continued]. What we are addressing here as we discussed earlier, when I was——

Mr. MCMILLAN. We would end up back in the same catch-22 situation that exists with respect to Medicare or Medicaid in that you would expect us to go ahead and spend it without having it.

Ms. FEDER [continued]. No, Mr. Chairman—Congressman, I am sorry, I think that the issue here is in contrast to Medicare and Medicaid, whether we create a system or a mechanism that causes us elected officials to review the operation of a system to see that it is indeed proceeding in the way that we expect it to proceed and to review it if it encounters any difficulties. It is that accountability that we are seeking.

Mr. MCMILLAN. That is not then a State responsibility to make up that fund?

Ms. FEDER. That is correct.

Mr. McMILLAN. They could exercise options to pass along a portion of that cost to the other existing participants in the alliance.

Ms. FEDER. Essentially, as I indicated in my response to the chairman, what we do see is a need to address the problems in the system. At that point, essentially we are all holding the bag. There is not a selected segment of the system that is—that would have to address that problem on its own.

Mr. McMILLAN. At one point, you had a provision in the bill that empowered the alliances to borrow money.

Ms. FEDER. We do have that but it is for a very limited set of circumstances.

Mr. McMILLAN. Would it be applicable in this case that I described?

Ms. FEDER. No, it would not.

Mr. McMILLAN. So conceivably we could reach—of course, it never happens around here—a situation of political gridlock in which the bills of the alliance could not be paid.

Ms. FEDER. Again, looking back to 1983 when the Social Security system was in danger, and when Congress did act quite responsibly in terms of making modifications, we see that as a likely model.

Mr. McMILLAN. Well, I would suggest that we need some further discussion about that point in time. I think there is a way, a different way to deal with this in which Federal Government is guaranteeing accrues to the individuals and not to the alliance, and the risk is truly passed on to a competitive marketplace, whereas under your system of capitated amounts and restricted competition, that risk is not adequately passed on and I think that is something we should work on.

Ms. FEDER. We are, of course, happy to work with you on mechanisms, but I think it is important to make a distinction here between the exhaustion, the unlikely exhaustion of subsidy funds and the works of the marketplace.

Essentially, as you know, we have a system with respect to cost containment that we believe will achieve the objectives that we set forward and that is really a separate issue from the question as to whether the subsidy pool is adequate. The adequacy of the subsidy pool has to do with potential economic circumstances that would have to be truly disastrous or cataclysmic in order to present a problem, but it is that kind of problem that is at issue, not the health care—the success of health care cost containment.

Mr. McMILLAN. I think, and if I may just conclude with this remark, one of the compelling reasons to really look at your cost assumption is that, historically, this place has underestimated the costs of the benefits that it enacts into law and that is the history of Medicare and Medicaid. And the President acknowledges that and we all know that. *where*

This is a prime example of *where* the water hits the wheel with respect to your plan. It is imperative that Congress have access to your financial assumptions and data runs. We cannot have a rational dialog about the President's plan without this information.

Ms. FEDER. And we look forward to an open discussion of those assumptions.

Mr. McMILLAN. Thank you.

Mr. WAXMAN. Thank you, Mr. McMillan.

Mr. Wyden.

Mr. WYDEN. Thank you, Mr. Chairman.

Dr. Feder, let me ask you about the situation you described for most of America where 88 percent of the people work at businesses of less than 5,000 individuals. It seems to me as I look at the structure, those employers, the employers with under 5,000, seem to have virtually no incentive to hold their costs down and engage in health promotion.

I look, for example, at the study that was in the New England Journal of Medicine that was by Dr. Koop this summer that indicated workplace health promotion programs are making a huge difference in terms of reducing sick days, outpatient costs, hospitalization costs.

What incentive do employers under what you are proposing have to try to do health promotion programs, hold their costs down, do some of the things that we know are working?

Ms. FEDER. Well, I think, Congressman, that they have the same incentive they have today with respect to keeping their employees productive and working. I assume what you are getting at is essentially now they share the health cost obligation they don't directly address that.

Mr. WYDEN. My point is, what you are doing for the workers is very sensible but it seems to me you are now taking the employers out of the ball game and the employers are showing us some things that are working.

Ms. FEDER. Well, I think again they continue to have an incentive to promote health to keep their employees coming in. We have done nothing to change that. They want everybody to come to work and be effective and I think all of that remains.

And as I indicated earlier, we think that the innovation that has occurred in the system has been led by the largest of firms and we have retained that continued incentive for innovation in health delivery by allowing those very large firms to continue to self-insure.

Mr. WYDEN. Well, I would be very interested in seeing any evidence that the only people that are making headway with workplace health programs are large employers, but I will tell you my sense is the reason we are doing this for people over 5,000 is politics, those people are really being given a political sweetheart kind of deal.

We found—we have been making some inquiries. For example, we found that a lot of these people with 5,000 individuals, they are basically just running a reinsurance program. They will in effect cover routine health costs through self-insurance and then they will join the big pool for the costs that they really need to pay insurance for.

I think aren't we just running something of a myth of self-insurance here by saying that 5,000 people are going to be a pool and that the number is really quite a bit greater than that?

Ms. FEDER. I don't think so, Mr. Wyden. I think that essentially what we are allowing is a segment of the marketplace at the high end where self-insurance is a viable concept.

And when asked earlier about why it is that we chose that number, I didn't particularly address that point, but I think that it is

a number at which self-insurance is regarded as a legitimate and doable thing and I think that is what we provided.

Mr. WYDEN. I will be interested in seeing that data because we have talked to firms of 5,000 and what we find is that they go out and self-insure for routine costs, they are essentially reinsuring for what insurance has to pay for, and my sense is the reason they are not in this is because of politics, and I question whether that is in the public interest.

Now, with respect to the National Health Board, I would be interested in knowing why we can't have the Board make recommendations, particularly as this proposal is phased in, about what America's health care priorities ought to be. What we have found in Oregon is that there are no easy choices.

The research does show that various kinds of treatments and services that work for some people don't work so well for others and why can't the Board for the future make recommendations that will allow us to have the information so that Congress can make some choices?

Ms. FEDER. Well, Congressman, we see when we look at the health care system and have examined it over the last several months, we see absolutely no reason for having in this system a mechanism for denying any services of value to people.

It is our view and it is fundamental to the President's plan that what we need to do is change the incentives and the style and the operation of our health care delivery system to hold doctors and hospitals and other practitioners accountable in the health plans for delivering the guaranteed benefits based on their premium bid and to assist them and hold them accountable for doing so efficiently.

And it is our view that that is the change that needs to be made in this system and that doing—proceeding down that route—will enable the health care system to provide people services that are of value to them.

Mr. WYDEN. I am not interested at all in making sure people lose what is of value for them. That is what I fought for all through my career in public service. It is just that we know we cannot pay in this country for everything in the health care system that somebody might conceivably say at some point would be of some value.

And for the life of me, I can't figure out why you all won't at least make recommendations so that we can see how for various individuals something may be really of value and something else may not be so valuable.

Ms. FEDER. Well, I actually think we have a very clear mechanism for focusing services, for assuring the value of service and that is in the relationship between the doctor and patient that is in the context of the health plan made on a direct basis taking into account all the circumstances that the individual patient puts forward. It is not a system of rules which may not adequately take into account those individual circumstances.

Mr. WYDEN. Well, on the doctor-patient issue, for example, we hear from a lot of physicians that they can't get much information on the comparative value of medical technologies. We are finding in this country that insurance companies, health maintenance organizations, they are buying technology in the dark and physicians

can't get this kind of information so that they can make these judgments you are talking about.

The proposal does nothing to try to help people get comparative information up front before a doctor buys a catheter or a piece of equipment before a health maintenance organization buys a piece of equipment and why not.

Ms. FEDER. Well, I think we do include those provisions, and if they are not strong enough, we need to work with you on strengthening them. Because we share your concern about that information and we have included in the plan the development of an extensive quality improvement program and a quality assurance system that will essentially provide us data that we have not had here to date that better enables everyone in the system, practitioners being a primary audience, to assess what works and what doesn't alongside a continued investment in outcomes research to enhance our capacity to use that data effectively.

Mr. WYDEN. Well, let's take an example. You are running a health maintenance organization in Portland, Oreg. A medical firm wants to sell you a catheter and you want information before you make that purchase as to how that new catheter would compare to what you are already using. Catheter is a big chunk of the budget certainly. Nationally, technology is responsible for 40 percent of the rate of growth.

How do you, under the administration's proposal, get that information about the comparative value of the technology prior to you making a purchase?

Ms. FEDER. Essentially, I think it becomes part and parcel of the outcomes research initiatives sponsored by the Federal Government of the promotion of valuation of effectiveness, of different techniques and technologies. And it becomes a job of that system, that quality assurance system to provide the information and make certain that information is available to plans.

Mr. WYDEN. If you are suggesting that the Federal Government is going to put such a massive sum of money up to evaluate these technologies, I am dying to see it because the one agency that is working in technology now, the agency for health care policy and research, is this itty-bitty agency. They are not possibly getting out the questions that the health maintenance organization in Portland and other buyers have, one, and tell me if—

Ms. FEDER. I think that is a fair point. I think that is a fair point, Mr. Wyden, that essentially they can address some of it but by no means all of it and if there are needs to strengthen the information availability, we would be happy to examine them with you.

Mr. WYDEN. My time is up, but I would just say, Dr. Feder—and I know of your interest in this issue in particular—what we have got to do is get incentives to the private sector to do these comparative technological assessments up front.

As you know, I have a proposal at your shop now. We are anxious to work with you on it, but it is 40 percent of rate of growth in health care in this country and I don't think we can gloss over it. Thank you.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you Mr. Wyden. I recognize members now for a second round of 5 minutes each.

Dr. Feder, just sort of following up a little bit on Mr. Wyden's questioning, you mentioned the quality. He was talking about technology, but what is the mechanism for assuring quality and letting consumers know about the quality of the various plans?

Ms. FEDER. Essentially we have incorporated in the plan the development of a quality improvement program that relies on the data that is regularly collected in a physician visit or in the course of a hospital stay along with enrollment data. That enables the plans, the consumers, the alliances, and all government agencies essentially to examine what the effectiveness of services is.

Mr. WAXMAN. So the plan is doing what is necessary to monitor its own quality by taking these inspections.

Ms. FEDER. What I was describing was the information system that enables plans to evaluate their quality but that information is also available to the State in certifying the plans. It is the State that is responsible for certifying health plans and quality is one of the measures to be examined in that process.

Mr. WAXMAN. At one point, the President talked about alliances doing some of this quality regulatory responsibility but now it is shifted over to the States.

Ms. FEDER. Well, the alliance continues to make information available to consumers and to plans through the Quality Performance Report or report card that is made available to consumers so that they can evaluate the plans they are choosing.

Mr. WAXMAN. So the basic place where we look for quality assurance through regulations and monitoring will be at the State level.

Ms. FEDER. That is correct, essentially, subject to the overall quality improvement program as developed by the Board.

Mr. WAXMAN. And what would that mean?

Ms. FEDER. The Board is essentially responsible for developing the quality assurance program, the measures of quality that are provided and—

Mr. WAXMAN. They would set up broad standards for what is good quality, what is good care, but it is going to be up to the States to say whether plan X or Y is outside the bounds of providing the quality that is required of them?

Ms. FEDER. I believe that is correct, Mr. Chairman.

Mr. WAXMAN. Now, this whole proposal is a State-based proposal and that has some advantages but also the potential to raise some problems. For example, a metropolitan statistical area could be split between two States and an employer in New York City could pay a different weighted average premium to an employee who lived in New Jersey than one who might live in Manhattan.

Health plans might want to serve a whole metropolitan area and to do that would need to deal with two different alliances, in some cases even two different States. Probably no single area shows the complications that can arise more clearly here than the District of Columbia where a small alliance would be responsible for carrying within its premium structure many unemployed and low income people.

Why did you go to a State-based system and how are you going to solve these kinds of problems?

Ms. FEDER. Well, we have gone to a State-based system, as you know, because it is the President's view that a national system, a

one-size-fits-all system, is not the best way to deal with the problems of our health care system. It is his view that in order to tailor the system and its operation most appropriately to the needs of citizens—we need a State-based system.

Mr. WAXMAN. He wants a State system and we have got a State system. How do you and he propose to deal with these very practical problems?

Ms. FEDER. Boundaries do pose problems, there is no question about that. Essentially one has to find mechanisms for dealing with them. When an area crosses State boundaries, there are explicit provisions that allow cooperation across the State boundaries, one would hope that that would occur.

It is clearly true that plans cross State boundaries, which I think is particularly significant for consumers in a lot—

Mr. WAXMAN. So you have to negotiate separate arrangements in different States, different alliances.

Ms. FEDER. That is correct.

Mr. WAXMAN. If they have to pay different rates for some employee in one State as opposed to another State, that is just the way it is?

Ms. FEDER. I think they pay different dollars now depending on health costs in different areas and that continues.

Mr. WAXMAN. Let's go back to the State-based program. We are letting the States take on those important regulatory functions and I want to know whether some of these things are going to be taken care of or whether they are going to fall through the cracks.

For example, who is responsible for monitoring quality? Obviously the State. But who makes sure the services are available in all these areas of the alliances? Who makes sure that red lining is not occurring? Who develops the services in areas where there aren't many providers? Who knocks plans out of the system if they perform poorly and who decides if the State is doing an adequate job?

If all these other responsibilities are the State's job, what happens if the State is not doing an adequate job?

Ms. FEDER. Well, they are all the State's job, as you indicated, and essentially the State—it is the duty of the State to provide its plan to the Board. It is the Board that judges compliance with those plans and when out of compliance there are mechanisms to respond.

Essentially, if a State is found out of compliance, then it is—in that unfortunate instance, it is the obligation of the Secretary of Health and Human Services to create a functioning system in that State.

Mr. WAXMAN. Thank you.

Mrs. COLLINS.

Mrs. COLLINS. Dr. Feder, the point of service enrollment procedure in the bill states that the individual in this situation would be assigned a health plan at random. Isn't it most likely that this enrollment procedure would be most frequently invoked in the case of lower income people and if so, wouldn't it be more sensible to enroll them in a health plan with the lowest cost sharing or the lowest premiums among the available options?

Ms. FEDER. Mrs. Collins, I think that the random assignment comes only if they have not exercised the choice, if they do have an opportunity for choice first and then if they have not exercised it, they are assigned and the reason for assignment is to ensure that a plan is held accountable for making payments to providers.

And if there are some adjustments to that particular mechanism that we need to examine further, we are happy to do that.

Mrs. COLLINS. Would it or would it not be an automatic thing that low income people would be placed in the least expensive plans?

Ms. FEDER. They are randomly assigned as you indicated across plans so that it does not have the result you explained—that is not the way it is designed.

Mrs. COLLINS. OK. And in addition to the annual right to change health plans, the bill would allow changes in enrollment at any time for a good cause. Now, I would like to know what good cause or what several good causes might be, if you please.

Ms. FEDER. Well, I believe it was—I don't know if it was you, someone raised earlier the issue of a plan that was really not delivering on its obligations that posed a problem in terms of the care of a patient. It would seem to me that would be my first interpretation as to what good cause would be but clearly that would have to be specified in regulations.

Mrs. COLLINS. Could you think of any others that might be for good cause?

Ms. FEDER. It seems to me what people are primarily concerned primarily about is their patient care, but I would be happy to think further about that and provide that for the record if you wish.

Mrs. COLLINS. Well, we will talk about it later then. The bill lists a number of categories of information that should be provided to consumers to aid them in the selection of the health care plan, yet some other items were not included.

Would you support including in that list a percentage of premiums spent by the health plan on administrative expenses, the number of complaints against a plan that is filed by consumers, and a description of the procedures used to control the utilization of services?

Ms. FEDER. Well, actually the last is a requirement of plans. The plans must publish those requirements and we are—I can't commit at this time but we are happy to examine things such that will strengthen this.

Mrs. COLLINS. Such as number of complaints and so forth.

Ms. FEDER. I actually believe when we look at consumer satisfaction, which is a key part of our quality surveys, that we would entertain that kind of issue as part of assessing consumer satisfaction, so although, as I said, I would need to look at the specifics, I think it is broadly consistent with our objectives.

Mrs. COLLINS. Could you tell me what the advantages and disadvantages of the State defining its Health Alliance as an arm of the government, a nongovernmental nonprofit entity, or a quasi-public/quasi-private entity of some kind would be?

Ms. FEDER. I think in terms of allowing or describing an array of options that a State might choose, that our concern here was to allow States flexibility in the way in which they choose to operate

a system. We did not want to predetermine that except to say that regardless of the administrative mechanism chosen, that the alliances are to be consumer run, essentially having the employers and consumers involved in the operation.

Mrs. COLLINS. Some critics have expressed some concern over the broad authority the plan would give to alliances to exclude health plans from competing in a particular alliance, even with the recent limits on excluding fee-for-service plans. I would like to know to what extent a Health Alliance would be able to exclude a health plan which is already certified to do business in the State in which an alliance is to be located.

Ms. FEDER. Madam Chairwoman, we have heard some of those concerns and responded to them as we put forward the legislative language and essentially the alliances accept all plans that are certified by the State with the exception that I raised if they have the option to exclude plans whose premiums exceed 20 percent of the average.

Mrs. COLLINS. Thank you.

My time has expired, Mr. Chairman.

Mr. WAXMAN. Thank you, Mrs. Collins.

Mr. Stearns.

Mr. STEARNS. Thank you, Mr. Chairman.

Dr. Feder, I would like to just return, if you would be so kind, to our chart here that we talked about earlier in which we talked about merely shifting the number of individuals enrolled in the various plans can result in actual premiums exceeding the allowed premiums under the Clinton plan.

Plans can either negotiate lower provider rate or tighten control over utilization, meaning fewer individuals get fewer services. At some point, however, plans may find that they are unable to pay doctors and hospitals less and are also unable to curtail services.

With a cap limit on premiums collected and an open-ended obligation to provide mandated benefits, many plans will be either forced to withdraw from the market or, worse, become insolvent. In the event of a plan's bankruptcy, the State may assess other plans within the State up to 2 percent of their premiums.

Won't even the additional assessment of 2 percent push other plans into bankruptcy since the average health insurer profit margin is only 1.75 percent, less than 2 cents on the dollar?

Ms. FEDER. Mr. Stearns, I think it is again appropriate to go back to the assumptions that are underlying your question because I think that what they suggest is a very limited time in the marketplace to enable providers to deliver health care more efficiently than they do today.

We have a great deal of confidence that under the new incentives in the system that there are tremendous gains to be had from greater efficiencies in the system, from more focus on delivering—truly having health plans focus truly on delivering quality health care at affordable prices rather than on risk selection. And, consequently, we don't foresee the pattern that I just put forward.

Mr. STEARNS. In many cases, a State may have only three to five health plans within each alliance. How do you propose to cover the cost of failure given the limited number of plans subject to premium assessments?

Ms. FEDER. Well, again, the number of plans obviously will vary with the population density and as many plans as there are, the alliance would accept.

On solvency, I would defer to Mr. Claxton.

Mr. CLAXTON. There are several pieces of the whole puzzle when you look at them that make it clearer—an insolvency should not have the same effect in the future as it has today. In terms of the amount of outstanding claims that are owed, with the electronic billing system and the administrative simplification as happens in this system, claims get paid fairly quickly so there is no reason to think that an insolvency would have many outstanding claims to be paid.

Individuals, when a plan becomes insolvent, are reenrolled into other plans very quickly so there shouldn't be any length of time in which the fund has to cover any claims. I think we are talking about a small amount of money.

Mr. STEARNS. The Clinton plan has maximum capital standards for health plans that might meet the Federal requirements established by the National Health Board under section 1505(I) of the bill. However when I turn to section 1505 on page 259, there was no section I outlining these requirements. Also, the State is to establish guarantee fund requirements in accordance with section 505(J)(2) but there is no section (J)(2) in the bill.

This is quite disturbing. Could you please explain why these sections are missing. It appears that there are a lot of sections missing from this bill. Now, we have—if you like, we can give this to you to confirm this.

Mr. CLAXTON. No, I understand the question. I believe the first reference was to 1503(I) or something or (J) or something like that.

Mr. STEARNS. 1505(I) of the bill.

Mr. CLAXTON. It should have been 1503(J). If you look, there is a section there. It is just a misreference and we do apologize for that.

Mr. STEARNS. There is no section (J)(2) in the bill but it is not——

Mr. CLAXTON. Section 1503(J), I believe. We can find the right reference for you. We apologize if the reference is wrong.

Mr. STEARNS. OK. In addition, the Clinton plan requires State designated agencies to assume control of failed plans. Typically failing plans will seek to merge with a healthy plan. How would State agencies handle a failed fee-for-service plan if only one or two existed in the alliance?

What would be the impact of merging a fee-for-service plan with an HMO or preferred provider plan? Wouldn't competition be seriously reduced? What do you expect consumers' response to be, especially in rural areas where they are forced into joining an HMO or PPO program?

Mr. CLAXTON. It is not clear to me that typically failing plans are merged with other plans. They sometimes are rehabilitated. They are sometimes brought back with new capital infusions and sometimes they are liquidated and their enrollees moved to other plans. It is possible that you can arrange mergers in certain cases.

I am not sure that is common with fee-for-service plans, but it doesn't occur to me there is anything in particular about this plan

that would inhibit the ability of a State regulator to find partners for a plan if that was appropriate or to liquidate the plan and find new enrollment for the people if that was most appropriate.

Each insolvency has to sort of be handled on its own basis in terms of what makes sense in that marketplace and that is what regulators do today.

Mr. STEARNS. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Stearns.

Mr. Wyden.

Mr. WYDEN. Dr. Feder, a question about ERISA. My State is ready to cover uninsured workers, in effect, before the President's proposal. I think there are some other States as well. It seems to me your bill thoughtfully goes about the ERISA question, but would the administration be receptive to giving my State and perhaps others this limited ERISA waiver earlier if we in effect were pursuing it with the same kinds of standards that the administration is pursuing in their overall national approach to ERISA?

Ms. FEDER. Congressman, I cannot speak to the specifics of an ERISA waiver predating the reform plan. What I can say is that we have included in the reform plan transition schedule a specific mechanism to allow States that are able to move rapidly consistent with the fundamental features of reform to do so and would be happy to work with any State to proceed in that direction.

Mr. WYDEN. On this matter of consumer information, I had a hearing in June and found that something like 33 States are bottling up essential information, information about C-section rates, information about hospital services, this sort of thing.

What about the idea of Federal law, in effect, preempting these State statutes that are restricting information that could be of such value to consumers. My concern is—I think the administration is on target with your report cards. I think it makes sense, but my concern is it probably is going to take us 10 years to get out that kind of information. Why not let a thousand flowers bloom now, go to bat for the consumer now, and in effect have Federal law preempt all these State laws that are bottling up information?

Ms. FEDER. Well, I certainly would share your concern about going to bat for the consumer and would be glad to explore any specific issues with you, but I think there is a concern about information and that it be good information and that is why we have invested as much energy as we have in the quality improvement program that is included in the President's plan.

Mr. WYDEN. I think your statement is valid. I would only say, consistent with consumer safeguards, let us override those State laws that have essentially been put in place by medical lobbyists who can keep the public from getting good information about this informational help to the consumer. If we don't, we are going to be sitting here for 6, 8, 10 years trying to get data on report cards.

Let me make one last point and get your thoughts on it as well. I share Chairman Waxman's views on this subsidy question. I am concerned that if you don't lock in the protection for the poor, you are playing Russian roulette with those vulnerable people. You don't want that and I don't want it.

It seems to me the better way to do it is rather than just say "trust Congress," why not build in a mechanism so that if those

caps on the subsidies are hit in any specific year Congress would then have to go after the programs that benefit the wealthy and the affluent. That way we wouldn't just say, oh, let's deal with it sometime down the road, wait for the Titanic to crash and all that kind of thing, but we have a mechanism for dealing with it in any given year that would lock in the protection for the poor that I think the President wants and you want.

Ms. FEDER. Well, I think, Mr. Wyden, that we have looked at a mechanism that would deal with a problem if it arose in any given year and essentially, as I indicated earlier, we think that in the unlikely event that the funds are inadequate, that we have a mechanism that deals with it or requires that we all deal with it for all Americans.

Mr. WYDEN. I think what you are really saying is we are going to trust the Congress and somewhere, someday, somehow, it is going to work out and I think it is a prescription at a minimum for chaos. It certainly increases the vulnerability of poor people. That is not what the President wants. That is not what you want and I hope we can continue to pursue a better way to address what happens if the subsidy cap is hit.

Ms. FEDER. If I may, Mr. Chairman, I would just say that it is absolutely not our intent to have—to hold the low-income population at risk. We do not believe that we have done that. And rather than describe it as you did, I would say that we believe that we are holding the Congress and the President accountable to all of us as citizens.

Mr. WAXMAN. Thank you, Mr. Wyden.

Mr. McMillan.

Mr. MCMILLAN. Thank you, Mr. Chairman. I can foresee Congress in the spring of the year, coming down to within 3 months of the end of the Federal fiscal year and being presented with a dire emergency appropriations bill of extraordinary amounts that would make what we look at today pale by comparison.

Section 1551 of the bill sets minimum capital requirements for plans offered by regional Health Alliances. Section B of that section states that the minimum capital requirements are \$500,000. Section C states the Board may require additional capitalization but there is no requirement that they do so.

Potentially in this system we could easily see health care plans enrolling tens of thousands of individuals with budgets in the hundreds of millions. I think the largest HMO in the State of North Carolina probably has in excess of 170,000 participants, so, to me, the \$500,000 equity requirement is ludicrous.

This is particularly true considering the committee's experience with Medicaid managed health care plans. Through Chairman Waxman's diligent work, this committee has identified many instances of Medicaid HMO's being grossly undercapitalized. This has led to managed care plan failures with the result that providers such as hospitals are owed millions of dollars. Obviously it has also led to disruptions of medical care that Medicaid recipients receive.

To some of this problem, the chairman at one point during this subcommittee's deliberations during the 1993 Reconciliation Bill offered a provision that required for-profit managed care plans to

maintain a ratio of equity capital to plan contract payments of not less than 10 to 1 under the \$5,000 equity requirement. The President's plan would simply provide an equity base for a plan of only about 2,800 people based upon your average \$1,800 cost assumption of the plan.

Would you give us the rationale for setting the capital requirements low and do you think it perhaps is something which is not targeted appropriately in the bill?

Ms. FEDER. I would ask Mr. Claxton to speak to that issue.

Mr. CLAXTON. Mr. McMillan, we spent a good deal of time looking at the capital standards and we looked at the variation across States in the minimum capitalization rates and what they do in terms of ongoing capitalization. Let me stress, first, that this is a minimum standard. We don't expect all States to necessarily come down to this, but in many States, their initial standards for HMO's and Blue Cross plans are less than \$500,000 so this is a floor.

At the same time, we asked the National Association of Insurance Commissioners to develop a risk-based capital standard, that would be flexible enough to address the needs for additional capital as plans grew and looking at the relation of types of competition they are up against, the types of areas they serve and the number of enrollees, and we fully expect that the Board will take their recommendation into account in developing additional capital standards for health plans.

I should say one of the other things we struggle with here when you look at the goals of rural communities to develop networks, you know, rural networks that can be health plans, we got a lot of pressure not to make this number too high in terms of initial capitalization of small rural networks.

What the \$500,000 does in combination with additional standards by the Board for risk-based capital, it allows a reasonable capitalization for small rural networks but then it could be flexible enough to have additional capital where necessary for larger health plans.

Mr. MCMILLAN. Well, of course, the Board doesn't have to accept NAIC recommendations.

I think this gets to the issue as to whether or not the President's plan is essentially going to foster competition or not. My conclusion because of a lot of other factors is that your proposal is going to force consolidation on an enormous scale, so that the 500,000 will be swept aside in short order by consolidation and that a company plan capitalized at 500,000 isn't going to survive at that level. Its risk base is not broad enough, and so forth and so on. This is something that needs perhaps additional attention.

Ms. FEDER. Congressman, we would like to pursue that with you because, as I think Mr. Claxton's remarks were indicating, we wanted a standard that was flexible. And it is our goal to foster competition, so we would be happy to examine that further with you.

Mr. MCMILLAN. Thank you.

Mr. WAXMAN. Thank you, Mr. McMillan.

Mr. Claxton, Dr. Feder, we appreciate you being here to walk us through some of these structural questions. It has been helpful

and, of course, we are looking forward to working with you further on this legislation.

Ms. FEDER. Thank you, Mr. Chairman and Madam Chairwoman.

Mr. WAXMAN. Our first panel this morning includes representatives of two States, Washington and Florida, that have recently taken steps to establish purchasing alliances to expand access to health benefits. While these efforts differ in some important ways from what the President's plan proposes, they do offer some valuable lessons about what we can expect from broader reform initiatives.

Margaret Stanley is Administrator of Washington State Health Care Authority. This agency has responsibility for purchasing health coverage for all State-funded programs including all State employees. Ree Sailors is the President and Chief Executive Officer of the Florida Health Access Corporation, a private nonprofit corporation established by State legislation. The corporation acts as a purchasing agent for about 3,000 small employers throughout the State.

I want to thank both of you for participating in today's hearing. We look forward to having the benefit of your experience in purchasing health care. Your written statements will be included in our hearing record in its entirety. What I would like to ask each of you to do is limit your oral presentation to no more than 5 minutes.

Ms. Stanley, we will start with you.

STATEMENTS OF MARGARET T. STANLEY, ADMINISTRATOR, WASHINGTON STATE HEALTH CARE AUTHORITY, AND REE SAILORS, PRESIDENT, FLORIDA HEALTH ACCESS CORP.

Ms. STANLEY. Thank you. I am Margaret Stanley, Administrator of the Washington State Health Care Authority. It is a pleasure to be with you this morning.

Washington State has passed the most comprehensive health care reform act of any State in the Nation. Our approach is similar to President Clinton's in that it relies strongly on private market incentives. By controlling costs through a combination of managed competition and macro level regulation, we will be able to provide access to affordable health insurance for all of our State citizens.

Health Insurance Purchasing Cooperatives, HIPC's, or Health Alliances as they are called under the President's plan, are assigned an important role in the managed competition model. I will use the two terms somewhat interchangeably.

There are several different methods to structure Health Alliances and the approach chosen by the President has merit. Health Alliances are quasi-public agencies governed by a board with broad representation. The primary role of Health Alliances will be to administer health coverage for everyone in a given region of the United States.

Health Alliances will also decide which health plans will be offered in an area and oversee the financing, marketing, and enrollment processes. Further, Health Alliances will collect, analyze, and publish data on all health plans they offer to give consumers the information they need to comparison shop.

Some of the benefits of the Health Alliance are that employers who currently do not offer benefits to employees will find it more affordable to do so, especially small employers.

Employers who currently do offer benefits will be able to offer more choice of plans to employees. There will be greater portability of benefits as workers change jobs. And standardized administration will lower costs for employers and health plans and make it simpler to administer.

It should also be less risky, as Health Alliances will adjust premium rates to plans based on the characteristics of the populations they serve.

The structure of the proposed Health Alliances in Washington State is somewhat different than the President's proposal. In Washington State there are two types of health insurance purchasing cooperatives, four private HIPC's, one in each designated region, and one public HIPC Statewide. Employers and individuals may purchase through the public HIPC or through the private HIPC or directly from health plans.

All employers are mandated to provide health insurance for employees and dependents, but they do have a choice of purchasing through the public or private HIPC or directly from the health plans in which case they must offer three to their employees, including the lowest priced plan.

The private Health Alliances or HIPC's, as I mentioned, are voluntary, not in competition with each other, self-starting; that is, they do not have government funds, member owned and governed, fairly large with a minimum of 150,000 enrollees. The regulatory power over them is split between two agencies, a Health Services Commission which sets standards, and the insurance commissioner, which implements and regulates.

The Health Alliances will be purchasers, not insurers, and they are required to offer all certified health plans.

All State health care purchasing will be consolidated under the health care authority, which serves as the public HIPC. We currently have an administrative budget of about \$26 million a year and serve over 300,000 individuals, which will expand to well over half a million soon under our health care reform. We currently have about 120 employees.

The scope of the Health Care Authority's responsibilities is similar to those of the private Health Alliances. We community rate, collect employer and individual payments, determine eligibility, contract with and offer 23 managed care plans. We risk adjust plan rates based on age, sex, and family size, and we are currently studying other methods of risk adjustment. We oversee marketing and enrollment and collect and distribute information to consumers.

We also operate a self-insured benchmark plan Statewide which allows us, consumers and purchasers, to measure the performance of other insurers against our self-insured plan's own cost control efforts. It also allows us to offer coverage in regions of the State which don't attract managed care plans or not enough of them, and for those consumers who travel or live outside of State, it provides coverage for them.

In order for this approach of public and private Health Alliances to work, there needs to be a fair and level playing field for both private and public purchasers; for example, having to play by the same regulatory rules, having equitable tax burdens, and spreading the burden of high-risk populations through community rating.

There are a number of issues worthy of further discussion which are described in my written testimony about competition among Health Alliances, governance and accountability, regulation and enforcement powers, size and so on. I will discuss just a couple quickly.

On the issue of competition, we believe that competition among private Health Alliances is not the best approach because Health Alliance size is critical and the more Health Alliance there is are, the smaller each is likely to be.

There could be cost shifting among competing Health Alliances. It could be inefficient with the requirement to create multiple administrative structures. And comparison shopping for consumers would be difficult. They would need to choose not only their own health plan, but also their Health Alliance. And benefits would be less portable as competing Health Alliances would offer different health plans.

In terms of governance and accountability, health allowances could be—Health Alliances could be quite powerful, but they are not unique in that regard. Government would need to have some oversight or setting standards and monitoring operations, and a clear plan of recourse in case performance is poor. They also should be required to disclose information and public records.

Mr. WAXMAN. Ms. Stanley, the rest of that statement is going to be in the record, but we are going to have to move on, limiting the testimony. But thank you very much.

[Testimony resumes on p. 72.]

[The prepared statement of Ms. Stanley follows:]

Controlling Health Costs and Expanding Access to Care: The Value of Purchasing Cooperatives

Margaret T. Stanley, Administrator
Washington State Health Care Authority

Washington State has developed the most comprehensive health care reform act of any state in the nation. Our approach is similar to President Clinton's in that it relies strongly on private market incentives to achieve what government-financed systems normally try to accomplish through regulation. By controlling costs through a combination of managed competition and macro-level regulation, we will in turn be able to provide access to health insurance for most of our state's citizens.

Health Insurance Purchasing Cooperatives (HIPCs), or Health Alliances as they are called under the President's Plan, are assigned an important role in the managed competition model. There are several different ways to structure Health Alliances, and the approach chosen by the President has merit.

What is a Health Alliance?

Health Alliances are quasi-public agencies governed by a board with broad representation (*analogous to "sickness funds" in Germany*). The primary role of Health Alliances will be to administer health coverage for everyone in a given region of the United States. Health Alliances will also decide which health plans will be offered in an area and oversee the financing, marketing, and enrollment processes. Further, Health Alliances will collect, analyze and publish data on all health plans under contract to give consumers the information they need to comparison shop.

What is the Value of a Health Alliance?

Employers who currently do not offer benefits to employees will find it more affordable to do so - A disproportionate number of uninsured Americans work for small-sized firms. Most small-sized firms lack the market clout to negotiate affordable rates with insurance companies. Health Alliances will consolidate the purchasing power of individuals and small groups in a given region, making health care coverage more affordable for all citizens.

Employers who currently offer benefits will be able to offer more plans to employees - Purchasing through an Alliance will make it easier and more affordable for employers to offer additional plan choices to employees. This is because employers will not have to incur the administrative costs for extra choices.

Greater portability of benefits - Individuals who enroll through a Health Alliance will continue to be covered by the same health plan as they move from job to job.

Consolidated administration lowers the costs and makes it easier - Health Alliances will centrally perform the administrative functions traditionally undertaken by individual employers and other purchasers. Standardized administration will also reduce the overhead costs for health plans which now deal with a blizzard of different forms and multiple enrollment and payment processes.

Less bureaucracy and greater expertise - Health Alliances will serve as the health benefits experts. Employers and consumers will have a cost-effective place to go to have their questions answered about quality of care, plan changes, network stability, benefits, cost, etc.

It may be less risky - Health Alliances will be able to detect plans which discriminate against enrolling sick people. Health Alliances also will be in a position to adjust health plan rates to account for legitimate differences. For instance, a health plan may serve a higher-than-average number of elderly people, either through random enrollment or because they specialize in geriatric care.

The Structure of Health Alliances in Washington State

Washington State has taken a unique approach. There will be two types of Health Alliances (*called "Health Insurance Purchasing Cooperatives" or "HIPCs"*): Four private HIPCs in designated regions and one public HIPC statewide. Employers may purchase through the public HIPC as well as the private HIPCs. In order for this to work, the playing field must be level for all purchasers, and the HIPC structure must be compatible with other system reforms.

Private Health Alliances

Health Insurance Purchasing Cooperatives are:

- **Voluntary** - Employers and individuals have several purchasing options and will only purchase through a HIPC if they decide there is a value to them.
- **Not in competition with each other** - There will be four regions of the state with only one HIPC allowed in each region.
- **Self-starting** - The private sector has the responsibility to form the HIPCs. The funding for administration and benefits comes from employers and individuals who purchase through the HIPC. There are no state or federal dollars that are used for the start-up or ongoing administration of the HIPC structure itself.
- **Member-owned and governed** - HIPCs are private, non-profit organizations. The Insurance Commissioner will review HIPC applications and appoint one HIPC each in four regions of the state.
- **Fairly large** - Each HIPC must have at least 150,000 people enrolled. This is large enough to develop adequate purchasing expertise, and operate with economies of scale.

- **Regulatory powers split between governmental agencies** - Regulation and oversight of the health care system is balanced between the newly created Health Services Commission (HSC), and the Office of the Insurance Commissioner. The four regional HIPC's primarily serve an administrative function. For instance:
 - The new state Health Services Commission sets standards for certified health plans and the Insurance Commissioner certifies and decertifies health plans based on these standards.
 - The Health Services Commission defines four geographic regions and sets the requirements for HIPC's. The Insurance Commissioner must approve the creation of a HIPC and will regulate its performance based on these requirements.
 - The Health Services Commission develops standards for benefit portability among certified health plans. The Insurance Commissioner implements and enforces portability requirements.
- **Purchasers, not insurers** - HIPC's are prohibited from assuming financial risk, and will offer certified health plans at the same community rate offered to employers outside the HIPC.
- **Required to offer all health plans** - HIPC's must contract with all health plans in their region.

State Purchasing

All state-funded purchasing for health care will be consolidated under one state agency, the Health Care Authority (HCA), over the next four years. Right now, the HCA's administrative budget is \$26 million a year to serve 565,000 adults and children. The scope of our responsibilities is similar to those of the private HIPC's. For instance, the Health Care Authority:

- **Community-rates premiums** - Currently, all public employees' premiums are community-rated. Over the next four years, other groups whose benefits are purchased by the state will be merged into this single risk pool. There is no medical underwriting for our plans and within the two years, pre-existing condition exclusions will be phased out.
- **Collects employer and individual payments** - We bill and collect employer and individual payments based on plan choice and the subscriber's financial situation.
- **Determines eligibility** - We determine initial eligibility for the programs we administer and monitor status changes.
- **Contracts with many plans** - The HCA runs its own self-insured plan and contracts with 23 health care plans.
- **Risk adjusts plan rates** - The premiums we collect for public employees are community-rated, but the rates we pay health plans are adjusted for age, sex and family-size. With funding from the Robert Wood Johnson Foundation, we are exploring better ways to adjust for health status.
- **Oversees marketing and enrollment** - In coordination with the health plans we contract with, we market our programs and enroll groups and individuals.
- **Collects and distributes information to consumers** - The state will continue to purchase benefits for public employees, the unemployed, and working poor. We will provide information to help consumers comparison shop for the plan that best fits their needs. In addition, we will help consumers understand the merits of managed care and the importance of taking responsibility for managing their own health.

The Washington State Health Care Authority (HCA) also plays a unique role by operating its own self-insured "benchmark plan" in all parts of the state. Our employer-managed benchmark plan will stimulate greater managed competition and allow consumers and purchasers to measure the performance of other insurers.

In the absence of a benchmark plan, the private managed care plans compete against one another. This has typically meant they perform as well as they must to remain slightly more attractive than their competitors, but not as well as they *could* do. The idea of a benchmark plan is to force the managed care plans to compete against an employer-managed "standard." This concept will help HIPCs determine target premiums, acceptable baseline price levels, utilization and service patterns and service quality. In the early days of managed competition, an employer-managed plan could serve to:

- Ensure regions have sufficient managed care activity to allow for true competition as new managed care plans form. Some areas within a region (*e.g., rural areas*) may continue to be unattractive as markets for private managed care plans.
- Cover consumers when they travel outside health plan service areas.

Level Playing Field Among Purchasers

Having the public Health Care Authority compete with the private HIPCs creates efficiencies, more plan choices in all parts of the state, greater innovation and pressures to keep overhead low. In order for this approach to work, there needs to be a fair and level playing field for both private and public purchasers. In the absence of public/private equity, adverse selection could systematically work to the disadvantage of one or the other purchasers, signaling the failure of managed competition. A level playing field includes:

- Having to play by the same health insurance regulatory rules.
- Equitable tax burdens.
- Availability and dissemination of consumer information and performance data.

- Balanced market leverage (*size and clout*) between private and public Health Alliances.
- Spreading the burden of high-risk populations fairly through community-rating and risk-management.

Issues Worthy of Further Discussion

Competition Among Health Alliances

Health Alliances will have vast authority over a service that is seen by consumers as critical to their well-being. If there is only one Health Alliance in each region, it will basically have a monopoly. To ensure this power is not abused, Health Alliances must be constituted and governed to assure that they meet the needs of the people they are to serve, within the budget allocated. Health Alliances will need to be designed to balance (*within an ever-increasingly tight budget*) the pressures from providers and health plans with the needs of consumers. Before implementing Health Alliances, a great deal of attention should be directed to the way they will operate and be held accountable for their actions. Having Health Alliances compete is one way to do this, but not necessarily the most desirable way. If Health Alliances are allowed to compete, they will soon be in the business of avoiding risk. Greater competition among health plans will occur if the Health Alliances themselves are non-competitive. All in all, the disadvantages of competing Health Alliances outweigh the merits. For instance:

- **Health Alliance size is critical.** The more Alliances in a region, the smaller each Alliance would be. Small, competing Health Alliances would not have economies of scale, the ability to hire expert staff or to mitigate the effects of adverse selection across plans.
- **Cost-shifting will continue.** Health Alliances competing for market power would likely shift costs rather than cut costs. This is one of the problems with the current system we are trying to fix.
- **It's inefficient.** Multiple bureaucracies would have additional and duplicative management expenses.

- **Comparison shopping will be more difficult.** Multiple Health Alliances would make it more complicated for consumers and health plans. It would be difficult for consumers to recognize which Health Alliances are the best performers.
- **It may impact the level of competition among health plans.** Competing Health Alliances may make it more difficult for new plans to enter the market. This in turn, may decrease beneficial competition among health plans that results in innovation and consumer responsiveness.
- **Benefits will be less portable.** Families with wage earners at different firms may not be able to obtain care from the same provider. Employees plan choices might change as they moved from job to job. The responsibility for dependent coverage would be more difficult to resolve. The more Health Alliances in a given region, the more seams there would be in the health care system.
- **Consumers may have fewer plan options.** Small competing Health Alliances would rarely have the capacity to offer the range of options that will be available through a larger, regional Health Alliance.

Governance and Accountability

While Health Alliances will be powerful and handling large sums of money, they will not be a unique structure. Similar governing bodies have been tried and found successful. School boards exert similar important control and authority over an equally important service. However, school boards are public entities directly accountable to voters, whereas Health Alliances are governed by private boards. Therefore, government will need to have some oversight for setting standards and monitoring operations; including a clear plan of recourse should a Health Alliance's performance prove deficient. This is particularly important if there is only one Health Alliance in each region. In addition, Health Alliances should probably be required to meet state investment rules, information disclosure and public records requirements.

Regulation and Enforcement Powers

Health Alliances will establish the criteria for choosing plans, selecting the plans, and determining how plans will be reimbursed. The Health Alliances will obviously have to oversee a number of activities of the plans, including how they market themselves, how they deal with complaints, and so forth.

The extent to which Health Alliances will be able to enforce the inflation limits depends on the statutory authority they are given, and is an issue that deserves further discussion. Some argue that Health Alliances must also have broader regulatory powers (*such as setting provider reimbursement levels, etc.*) in order to meet the cost-saving targets and enforce inflation limits. Others argue that the invisible hand of the competitive market will result in lower inflation rates in health care premiums; and that this is a much stronger mechanism than the ability of the Alliances to enforce the inflation limits.

The risks of consolidating all the regulatory power in one quasi-governmental body should be carefully weighed. Other models that balance and separate the regulatory responsibilities across governmental agencies may achieve the desired results without the risks.

Size and Boundaries

There is probably no "right size" for a Health Alliance, and there may be some need to have different thresholds in different parts of the country (*depending on population density*). As we have considered the tradeoffs among various sizes, we have concluded that Alliances should be relatively large to ensure portability of coverage, competition among health plans, administrative efficiencies, and to ensure that market power results in true cost-control rather than cost-shifting. While there may be some good reasons to allow larger-sized firms to purchase outside the Health Alliance (*e.g., inter-state and inter-regional employers*), setting any threshold by employer-size is fairly arbitrary. Since large employers, under the President's plan, have the option of either purchasing from health plans directly or purchasing from a Health Alliance, the adverse risk to Alliances which might result must be addressed. In addition, depending on the size and market dynamics of a region, allowing large-size employers to opt-out may adversely limit the size of the regional Health Alliance.

Each Health Alliance should cover a geographic area large enough to maximize portability of benefits as people change jobs within a community. The larger the Alliance, the greater the opportunity to foster competition among health plans and to reduce administrative overhead due to economies of scale. The geographic region should also be large enough distribute the higher risks of some "community pockets" where there is a known correlation between socio-economics and health status. It may be difficult to establish regional boundaries that make sense for the Health Alliances given existing state and city structures, but it certainly is not impossible. For instance, special circumstances could be allowed when a metropolitan area crosses state borders.

Employer Options

Choices will need to be made about the role of Health Alliances. Is the role for Health Alliances mainly centralized administration and expertise to minimize the burdens of an employer-based system? Are they primarily to give small groups and individuals the same advantages as larger purchasers or are they the general manager of health plan competition and global budgets? How you answer these questions will determine what purchasing options employers should be allowed to have. The advantage of giving employers the choice is that those who have historically provided access to coverage for their employees and feel strongly about their direct involvement will be allowed to continue. The disadvantage of giving employees many purchasing options is that it becomes more difficult to manage adverse selection and the distribution of medical risk. In addition, employees who work for employers who purchase health benefits directly may lose portability when they change jobs.

Trade-Offs Between Market Leverage and Plan Choices

Health Alliances may have too much market power if they are allowed to exclude health plans. Health Alliances that limit the number of participating health plans could pose insurmountable barriers to entry for new health plans or for existing plans that are not chosen initially. Over time, the fear is that only a few health plans will be available in a region. An alternative is to establish tight criteria for Health Alliance participation and allow all health plans that meet these criteria to participate as long as they continue to meet the criteria and maintain performance standards.

Trade-Offs Between Negotiating Lower Premiums and Cost-Shifting

Unlike Washington State's legislation, which requires community rating, Health Alliances under President Clinton's approach will be able to exercise market power in negotiating premiums with health plans. This may result in stronger incentives for plans to shift costs to other purchasers rather than to get serious about cutting costs. In addition, unless the negotiation process is somehow invisible to employers, there may be perverse incentives for employers to hire certain types of employees to keep their costs as low as possible.

Conclusion

Purchasing cooperatives and alliances play an important role in managed competition. We are pleased you are including them in your discussions of health care reform. As you are aware, there are critical technical issues to address, but the concept makes sense. It is fair to expect purchasing cooperatives and alliances to work far better than anything we have yet tried.

You may want to allow states to test different models to measure the value of mandated purchasing through cooperatives and alliances versus allowing employers to choose.

Analysis is needed to determine how large Health Alliances need to be in order to develop adequate purchasing expertise and to limit cost-shifting among purchasers.

Health Alliances will need to develop new methods for distributing medical risk among competing health plans. These methods do not currently exist, but they are critical to spur competition and innovation in ways that are fair over the long run.

Governance and accountability are important to define on the front-end rather than wait until there is a problem. If structured correctly, a single, regional Health Alliance is far better than multiple, competing ones.

States have been the leaders in innovative and prudent purchasing methods. The HCA has far lower premium rate increases than our private counterparts and has saved millions of dollars by implementing innovative purchasing approaches. Medicare has been far ahead of the purchasing pack in putting cost-saving payment policies into place. The state of Maryland has consistently kept its rate of growth in hospital spending well below the national average since its hospital rate setting commission was created in 1976. It makes sense to build on what has worked effectively by consolidating each state's purchasing power under one agency, in essence creating a public Health Alliance. There are bankable benefits to maintaining a large purchasing role for the state as long as there is a level playing field for both private and public purchasers.

President Clinton's health alliance approach certainly has merit. We are excited about Washington State's role as a laboratory for developing workable health care reform for the country.

Mr. WAXMAN. Ms. Sailors.

STATEMENT OF REE SAILORS

Ms. SAILORS. Good morning. My name is Ree Sailors. I am the President and CEO of the Florida Health Access Corporation. I am very pleased to be here, although I do get nervous when I come up here to the big leagues.

The Florida Health Access Corporation is a quasi-public service corporation, if you wish. It is a private, nonprofit corporation whose creation was called for by State statute. The Board of Directors of the corporation is appointed by the Governor of the State, and we, I think, have been invited here today because we may be one of the few living specimens of a real life operating, purchasing alliance that has been in operation since 1989.

We are the prototype for the HIPC's. We are the prototype for what has now been adopted as a Statewide system to be implemented in Florida, which is called a system of CHPA's, or community health purchasing alliances.

We work with and originally our target population was exclusively the chronically uninsured small businesses in our State, which from a marketing standpoint is the hardest rock to crack. We have worked with over 3,000 small businesses who are enrolled and receiving coverage through our program.

We originally started out negotiating with health plans and promising them all of our volume in exchange for best pricing. As we have grown and our membership has grown, we have gone further to emulate the actual HIPC model which is to provide a menu of health plans available to our members, from which they can select.

We currently are serving 25 counties in the State. We do monthly premium billing collection, we do enrollment, we do payment to the health plan, and we have administered a subsidy program to the employers in order to provide affordable health coverage to them.

I think what I would like to do—the written remarks are in the record—a few comments about some of the questions I heard earlier.

Number one, on the issue of choice, I think the reality is that most people don't have the advantages that some of you may have in dealing with the Federal system and its massive amount of choices for health plan. The reality is most people have a limited number of health plans to select from, either through their employer, and so that choice really becomes in terms of the real world, the choice is usually a choice that employees have between an indemnity plan, a PPO plan, and an HMO plan or maybe two of each, but that is about as far as it gets out there, even in large companies with massive numbers of employees. For small companies, that choice has been virtually nonexistent.

To give you an idea of demographics in the State of Florida, we have over 310,000 small businesses who have 50 or fewer employees. And over 200,000 of them have four or fewer employees. I think that is a characteristic that we need to understand. The other thing I would mention that I think is essential—it is hard to keep track of all these buzzers.

The other thing that I would think is essential is the opportunity and some actual experience we have had to negotiate with health plans and how important I think it is to be able to throw out the outlier. We had that experience and opportunity just recently in the last 9 months. We went into extensive negotiations with health plans. They had heard in the past that all of our business would come to one of them. We came back and said, no, not this time. This time you will compete among each other to get the business of our membership. That changed the nature of the negotiations dramatically.

And on top of that, we said to them at the point in the negotiations when we said to them we reserve the right to throw out the high cost plan, we started getting in excess of double digit concessions. That dramatically affected the pricing that came into us. It very dramatically affected the bids that were provided to us. And it was an amazing thing.

Unfortunately, this is one of those areas that brings up another area that I think you need to be careful about, and that is we do not disclose the proprietary information, and because we take our negotiations very seriously, and therefore we can't always show people how good it has happened, but I can assure you that we have gotten in excess—no single digit stuff, we don't deal with that—we are in double digits, and clearly into the double digits. I think that is an incredibly important thing.

I think it is also important to look at these purchasing alliances for what they are and not for how we have been in the past. They are not regulatory agencies. They are agents in the marketplace on behalf of consumers and they provide an opportunity to empower consumers, who I will quote from Network, the movie, "We are mad as hell. We are not going to put up with it anymore."

This opportunity means that you also must allow them to operate without their hands tied behind their back in the marketplace. And that means allowing them to have the privacy of negotiation strategy, to have privacy when they develop their RFP's, and not to have that exposed to the public when that is happening to the competitors and to the health plans and providers who have vested interest and who would never open their board rooms to us to be witness to their strategies.

So I think that is an extremely important thing if you really want to mount a competitive market-based set of strategies, then you have to remember what it is like to conduct business and not just government.

Thank you.

[The prepared statement of Ms. Sailors follows:]

TESTIMONY
OF
REE SAILORS, PRESIDENT & CEO
FLORIDA HEALTH ACCESS CORPORATION

The Florida Health Access Corporation (FHAC) is a private non-profit corporation whose creation was called for by state legislation passed in 1987. FHAC was commissioned to find ways to bring affordable and accessible health coverage to small businesses. Originally we were aimed exclusively at chronically uninsured small businesses. FHAC began as a joint venture among the State of Florida, the Robert Wood Johnson Foundation and Hillsborough County. The program has historically served small businesses with fewer than 20 employees. Health coverage through Florida Health Access is presently available to small businesses in 25 counties; enrollment includes approximately 3,000 small employers and their workers and dependents.

We were a prototype of the theoretical Health Insurance Purchasing Cooperative (HIPC) or purchasing alliance. Florida Health Access organizes small businesses into buying pools. Initially, we negotiated with health plans for pricing and offered an exclusive contract to a single health plan which in turn would receive benefit of our entire potential membership. Florida Health Access also took on direct responsibility for enrollment, monthly premium billing and collection, administration of subsidies for employers, certain customer servicing functions and sales management. On a monthly basis, we currently bill each of our small employers, collect premium and in turn, remit payment to the respective health plans for the enrolled population along with appropriate data changes and updates.

As we grew in numbers and insight over the years we shifted to offering a menu of health plans to our members with a common comprehensive benefit package. Consequently, our customers and potential customers are able to shop based on price, composition of provider networks, reputation for quality, and convenience. Each year at renewal, members have the opportunity to change health plans based on their selection and relative satisfaction. Rate concessions from the health plans have been achieved consequent to our assumption of direct administrative functions. Additionally, we have been able to successfully negotiate trend factors in our latest health plan contracts which limit future rate increases to single digit inflation.

As you may be aware, the Florida Legislature with leadership from Governor Chiles has recently passed health reform legislation which sets universal coverage as a goal and proposes the establishment of eleven (11) Community Health Purchasing Alliances (CHPAs) as buying pools for small businesses and ultimately state employees and Medicaid recipients. The establishment of the CHPAs is underway and

it is anticipated that coverage will be available through the purchasing alliances effective as early as April or May of 1994. FHAC is working to assist with the development of the CHPA system.

SOME OBSERVATIONS

Having had a few years to wrestle with the health coverage marketplace and small businesses, we would make some observations:

Instituting the benefit within the business is a very significant decision on the part of a small business owner;

Most small business employers want to provide the benefit but affordability is a major obstacle;

Subsidies to small employers are a practical necessity and perhaps a moral obligation (if mandates are contemplated); and subsidies might not have to be forever, but focused on market entry and stabilization;

The small group health coverage market is not accustomed to organized buying and often tries through legislative lobbying to reconstitute the large buying pool back into small groups;

It is extremely intriguing to imagine what might happen if the dialog between buyers and sellers of health coverage were a "fair fight".

SPECIFIC ISSUES AND QUESTIONS

** Some have asked whether exclusivity for the alliances is necessary. I would answer the question differently by saying that if there was no exclusivity then there should at least be the authority to actively negotiate with health plans. Without the authority to negotiate it would not be a fair contest. Any corporate benefits manager would lose their job if they simply accepted the first proposal of health plans. Why should small employers settle for less?

** What size employers should be included in the alliances? The administration's proposal would take all but those companies with 5000 employees, I would probably lower that number to 1000 or 750. Much innovation and creativity in buying strategies has come from employer coalitions and self-insured employers. It would seem premature to cut off that learning pool and its creativity. If their numbers are needed for financing mechanisms for aspects of the overall

plan, why not handle it as has been proposed for teaching and research costs.

** Some have questioned whether it is realistic to limit increases on premiums. I believe it is important if not essential. As mentioned previously, we have negotiated rate trend factors in our contracts with health plans. Some of those trend factors are at a maximum of 8%. Plans seemed to have confidence in their ability to handle these limitations. Similarly, if maximum allowable rates of increase are a known factor I believe it will assist the health plans in their provider negotiations. Everyone will know what the limits are and know that they cannot exceed them. Those plans who can further contain increases will most likely be more successful. I say this because we are convinced that "shopping" is guided by price in conjunction with provider networks. Also, it is imperative from the consumers' perspective that health care providers and plans learn to live within the same limitations that the rest of us have to live with relative to Consumer Price Index (CPI) and growth. We can no longer tolerate within the health care market the unbridled, undisciplined growth of decades past.

** Questions have been raised about the scope of responsibilities for alliances and the resource cost of these functions. The scope of duties described is very comparable to our current set of functional activities, differing in our lack of risk adjustment payments to health plans. Technically, as you know, this is an area that has not yet fully developed. Our estimate of cost for the other administrative functions would be approximately \$4.00 per member per month once a volume of approximately 50,000 members has been achieved.

As a forerunner to this aspect of the national and state reform efforts, we have been well educated by the small business community and the traditional and evolving health coverage market. We have worked hard to forge some changes despite laboring under the disadvantage of "only being a pilot program". We have tried many things, learned much, but most importantly earned the respect of our customers, the men and women who work in small businesses. I appreciate the opportunity to share some of our experience and opinions with the members of the subcommittees and encourage you to ask any questions to which we might be able to respond. I encourage the Congress to hold whatever hearings they need to understand the very complex problem. Most of all, I encourage you to take action. I believe consumers are the sleeping giant waiting to be awakened. The purchasing alliances represent the mechanism for consumers to engage actively their right to fully participate in the health care marketplace and as such are an integral part of necessary reform.

Mr. WAXMAN. Thank you very much, Ms. Sailors. Both of you have given us very helpful testimony and I appreciate it.

As you both know, there has been a lot of discussion about whether Health Alliances should be exclusive purchasing agents for their members, or whether alliances should be allowed to compete against one another.

Ms. Stanley, you testified that if Health Alliances are allowed to compete, they will soon be in the business of avoiding risk. And, Ms. Sailors, you stated that if Health Alliances are not exclusive, then it would be necessary to give purchasers the authority to actively negotiate with health plans.

Can each of you tell us what you think will happen if regional Health Alliances are allowed to compete with each other? What would be the impact on premiums and on administrative costs if such competition were permitted?

Ms. Stanley.

Ms. STANLEY. Mr. Chairman, I think that competing private Health Alliances are—will add an unnecessary layer. I also believe that a significant amount of expertise required to run one and if they are too small, it will be difficult to get the necessary expertise in the management structure.

Also, I think it will impede portability of plans and will increase the administrative costs because you will have administrative costs in the health plans and then again in the Health Alliances. It may also make it more difficult for people to choose.

Mr. WAXMAN. Ms. Sailors.

Ms. SAILORS. Mr. Chairman, I would agree in the sense that I think as you have the repetition of these things, you are replicating an administrative structure. That is part of the ultimate theoretical design of why you have the HIPC's, which is to get the redundant administrative costs out of the system. So I would agree with that.

I understand also political realities and that sometimes people bend under those pressures, and that is why I said in my own testimony that if you—if you are going to put them in competition, I would limit the number that can be available within certain population segments. And I would also absolutely give them the power to negotiate. If you do not, then you have literally tied one arm, one leg behind their back.

Mr. WAXMAN. I would like to ask both of you to comment on the size of the regional Health Alliances proposed in the President's plan. I think we can all agree that there is probably no right size for an alliance, and any employer size we might choose is, to some extent, arbitrary.

On the other hand, size is crucial to the basic purposes of the alliance, creating a buying group that is sufficiently large to assure effective leverage in the marketplace, and fairly spreading the cost of health services, including subsidies for small, low-wage employers, or for low income people for essential community employers providers and for academic health centers.

Can you tell us how you would go about determining the size for alliances and how you would assign responsibility for those outside the alliance to contribute their fair share to subsidize costs?

Ms. STANLEY. Mr. Chairman, our State health care reform law says that employers who have over 7,000 employees may form their

own registered employer health plan, which must meet all the same requirements as the other certified health plans. But they can restrict their enrollment to just their own employees and dependents.

I don't think there is a magic answer in terms of the size. In our State, it would be fewer than 10 employers who would meet that requirement of 7,000.

Mr. WAXMAN. Ms. Sailors.

Ms. SAILORS. I would answer the question two ways. First of all, as I said in my testimony, I think of the threshold of 5,000, I would say might be a little high. And my primary reason for that answer comes from two things.

One, I think there is innovation coming to us from the self-insured employer groups. And also I might say that my answer was tempered by the experience I have in Florida where smaller large employers have banded together into employer purchasing alliances themselves so that I didn't necessarily see the 750 size company as a stand-alone, but as the opportunity to coalesce with colleague type companies of that size in order to get a purchasing alliance opportunity there.

The other side of the equation is: How would you size the alliances and that is how would you maximize their economies of scale? And I think that there are ways that you can look at what the administrative costs are and there are certain levels. For instance, at memberships below 50,000, administrative costs are higher as a percentage of premium but once you reach 50,000, to 70,000 members, you reach a certain level of economy of scale and it plateaus, it begins to plateau off.

So, therefore, I would say you would want to have a minimum size that would take you into that 50,000 to 75,000 member range at the very least in order to achieve some of the administrative economies of scale that you are going to have to have.

Mr. WAXMAN. And I also asked you about assigning responsibility for those outside the alliance to contribute their fair share for subsidization. How would you do that?

Ms. SAILORS. I don't claim to be an expert on this, but I would use—I would address it similarly to the proposal to assess teaching and research costs. If they are not in the alliance, then those are universal costs, we want them across the largest base of population possible, and that if there are people outside the alliances, they ought to be assessed that universal cost which is I think for those who cannot afford the subsidies, teaching, research, et cetera, kind of thing, I think you could use similar methodologies.

Mr. WAXMAN. Thank you very much.

Mrs. Collins.

Mrs. COLLINS. Ms. Sailors, in absence of Federal legislation such as the President's bill, would the plan you have in Florida which focuses on the community health purchasing alliances provide universal health care in Florida?

Ms. SAILORS. It is our goal in Florida to get all of the citizens in Florida covered through the initiative, as you may know, of Governor Chiles. That has been a goal set by our State legislature to achieve that. I have some doubts whether or not we would be able to achieve it as a State alone.

I think there is a need for Federal leadership. I think there is a point at which States can go no further for a variety of reasons, including some of them political. The mandate I think is an unpalatable but necessary evil, because the ineluctable truth is that without it, there are free riders and the free riders create cost shift and inequities.

And in the long run, States can try, and in our State, we failed to be able to pass the mandate. I think it is left to the Federal Government to probably say and, you know, suck it up and say you are just going to have to because there are no free riders in this system anymore, and that we, with that, will carry the moral obligation to provide subsidies to make it so that it is affordable to people without overburdening them.

Mrs. COLLINS. Thank you. Ms. Stanley, in your State, in choosing to establish a mandate on employers, like in the President's bill, I guess you rejected the idea of establishing a mandate on individuals.

It seems like you might have also rejected the idea of voluntary participation by employers which is an idea that has been embraced by Mr. Cooper. And the question is: Did your State consider either of these options? And if so, did you conclude that universal coverage could not be achieved through those methods?

Ms. STANLEY. Our State, in addition to having the employer mandate, does require that individuals purchase health insurance by 1999, which is when the expansion of access to the uninsured and the employer mandate for both employers and dependents would be fully phased in.

We did not consider a voluntary option. We did consider a single-sponsor option, and if the State of Washington should fail to receive an ERISA exemption, we would revert to the single-sponsor option which does not require it.

Mrs. COLLINS. Thank you. Under the President's proposal, State governments will have the primary responsibility for the regulation of health plans with some guidelines and standards from the National Health Board. Now the Health Alliances would still have much authority with regard to the setting of health plan premiums and some other matters.

My question is twofold, and it is to either of you or both of you, but I am going to address it to you, Ms. Stanley. And one is: Is this an appropriate division of authority? Would you like to see it altered in some way? And the second question is: Who should have primary responsibility to ensure that health plans don't engage in medical redlining of any kind and similar discriminatory practices?

Ms. STANLEY. I think it is appropriate to give substantial powers to the State. States deal with many of those powers now, for example, through the Insurance Commissioner's Office, and our State has established a five-person Health Services Commission to oversee health care in the State of Washington. It would be very appropriate for a group such as that to make sure that there is no redlining by health plans.

Mrs. COLLINS. Ms. Sailors?

Ms. SAILORS. I would think it would be appropriate and I wouldn't see any massive shifting. I think what the Health Alliance has—purchasing alliance has as its tools are, one, a form of report

card, if you wish, that I think it can conduct independently about movement of membership across plans inside their own localities.

And, also, I think I feel very strongly about the power that I don't think everybody comprehends of the power of the ability of the individual employee to select. That is a very major change. And they can walk away from that plan at reenrollment each year if they have been dissatisfied with that.

I happen to have a lot of faith in the consumer's ability to judge a health plan without techno jargon even, that they know whether or not they are getting treated properly. And so I think that is a huge tool for the consumer that has heretofore been unavailable to them.

Mrs. COLLINS. If I may, I would like to ask you what about the low-income consumer; would that person have the ability to walk into other plans?

Ms. SAILORS. Absolutely. Under the purchasing alliance, at the employee level choice or the individual member level choice, basically I put before my members a menu of health plans and they select, they can select at the individual level the—the individual person level kind of thing. And that means that they can walk from plan to plan.

Now, what the contribution rates are, the contribution rate of the employer remains stable irrespective, so if they opt for a higher cost plan, there is a higher cost consequence to that, too. But, likewise, what they have seen in our experience, when that choice is put available to people, we do see them walking at times, both to lower cost and higher cost plans, and also the variables of whether or not doctors are represented in both—more than one plan affects their ability to walk and their willingness to walk, too.

But as I understand the way, this would work, and the way we have been working our own system out, that individual has the opportunity to leave that plan if they feel they have been treated shabbily. And I mean that from an attitude, how long do you have to wait when you are supposed to have an appointment, how long do you have to wait to get an appointment, whether or not you feel like you were properly treated, if you got well the way you were supposed to, if your doctor is working with you in partnership or talking down to you like you are some idiot, which are things that consumers care about.

Those are all options available each year at the annual reenrollment time. The menu is back up and available to them in full. I think that is an enormous tool, a very powerful tool.

Mr. WAXMAN. Thank you, Mrs. Collins.

Mr. Stearns.

Mr. STEARNS. Thank you, Mr. Chairman.

I want to welcome, of course, both of you, particularly Ms. Sailors who has come from my home State of Florida. You will be happy to know it is as cold in Florida today as it is up here almost.

Ms. SAILORS. I heard it was colder.

Mr. STEARNS. I just want to follow up, listening to both of you, I keep thinking what happens to the independent insurance agent? You know, under the Clinton plan, insurance coverage may only be purchased through the Health Alliances and not through insurance agents. Many Americans and employers have come to rely on the

health benefits expertise of these agents. And obviously Americans then are going to decide for themselves.

Does the plan indeed eliminate the role of insurance agents altogether?

Ms. SAILORS. No, not necessarily. We use licensed insurance agents in Florida, through Florida health access, we always have. What I do think is that the insurance agent's role in the system is changing and that the insurance agents need to see some handwriting that is on the wall.

What we have done is, we have—we do the sales management function. We recruit through a competitive process and contract with a selected number of agents who represent the products available on our menu to the public. We think they are extremely valuable in terms of explaining for the public what their options are and helping them shop through the options in terms of what is the right match for them.

We think that, historically, the ways that agents—and I am talking about Florida Health Access and my management philosophy on behalf of my customers—we think the way agents have historically been paid for their work may be inappropriate. The fact that the—

Mr. STEARNS. Be inappropriate?

Ms. SAILORS. Compensation has been tagged as a percentage of medical premium, which has been subject to three times the increase of the CPI. And that their work load does not increase at three times the CPI or anything close to it, and that that is a veritable snowball from hell in terms of how it comes down on you.

We would like to change those things and have talked about doing that. What we finally found out, though, is as you neutralize those things and you neutralize the commission paid to agents across the board irrespective of product, which the California HIPC has done and we have done, is that agents' alliance to customers increases and their alliance to companies potentially decreases. And we think that we would like to have the agents working for the consumers and I think it more clearly identifies those lines when you do those kinds of changes.

Mr. STEARNS. Let me just follow up to you, Ms. Stanley. Do you also agree that the insurance agents, using her words, should see the handwriting on the wall, what will be in your opinion the role of agents and employee benefit specialists under the Clinton plan?

Ms. STANLEY. Well, I think that there probably would be a diminished role, particularly with the existence of Health Alliances. In our State employers—

Mr. STEARNS. Do you see the number of them going down or increasing?

Ms. STANLEY. Potentially, I think that they would—

Mr. STEARNS. Going down, less number of them?

Ms. STANLEY. I would guess so, and they might specialize in other fields of insurance besides health. We are using consultants more as experts to us rather than as brokers or as agents paid on commission. And I think for under our State-based reform plan where employers have the option of buying directly from health plans, that they would play a useful function in advising those employers of the types of plans that are available to them.

Mr. STEARNS. Ms. Sailors, your testimony indicates that there should be limits on premiums and indicate that trend factors are, at a maximum, 8 percent. While holding premium increases down will help to contain costs, do you think that it is possible to hold premium increases to inflation plus population growth, 3.5 percent plus 0.8 percent, 4.3 percent, a total, as the Clinton bill has authorized?

Is it possible, given that no other country has been able to achieve this feat, that it is a reasonable objective?

Ms. SAILORS. Well, let me—overnight, no. As a phased-in approach and a set of created expectations for us, a set of goals for the entire medical industrial complex, I think it is a worthy goal and I say that as a consumer.

What we found in our negotiations is that we have been able to negotiate trend factors in our contracts with health plans and that we have gotten down to 8 percent at a time when it was running double that on an average kind of thing. And we seem to be able to live comfortably and the health plans seem to be able to live comfortably with that type of thing. We are comparatively a small group compared to what these purchasing alliances would be.

I would also point out to you that part of this reform as I see it, and as we have experienced it so far, is that you are doing a major shift of changing the unit of purchase for the consumer. You are no longer beginning to buy health care by procedure, you are buying it by the health plan. And what happens is the incentives to the health plans to begin to manage their resources more appropriately have increased significantly. That is what we need to do.

Part of the equation between the American public and the health plans, I think, is that if you want to continue to earn off the float of the dollars, then the services that we will extract from you in return for that are we expect you to have and apply increased management over the resources, to use what works and throw out the stuff that doesn't, to use it appropriately and to quit using it inappropriately.

And I think those sets of incentives are implicit in a lot of the ways that we are talking about buying health care under this plan and under the plan that we have been running.

Mr. STEARNS. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Stearns.

Thank you both very much. Yes, Mr. Sharp.

Mr. SHARP. Would the chairman yield for one question?

Mr. WAXMAN. Yes. The gentleman is recognized.

Mr. SHARP. Thank you very much.

Ms. Sailors, I am just simply trying to understand what the administration is recommending in terms of Health Alliances. What is the nature of the beast, how will it function? And I am hoping you can help me understand whether or not you see it as very similar, nearly alike what you are doing, or is it quite different?

You said, give it the power to negotiate. I guess that raised the question in my mind, do you see that the proposal so far does not leave the alliance the power to negotiate in that way?

Ms. SAILORS. The power to negotiate was in conjunction with whether or not there should be competing HIPC's or CHPA's or whatever these things are called in whoever's version it is kind of

thing. I say if they are going to be competing and nonexclusive, then absolutely, they must have the power to negotiate.

We have been nonexclusive and competing out in the open marketplace and we do have the power to negotiate. The CHPA's that are going up in Florida will be out there and they are currently not allowed to, and I think it is an absolute miserable mistake.

So I would say, you know, I think under the Clinton plan, they have them as exclusive channels, therefore maybe the power to negotiate isn't absolutely necessary, but the power to throw out the outlier, I think, is real important. Because, otherwise, my sense from experience with health plans, and this is not to detract from any of our partner health plans that we have contracted with, but they tend to gravitate to the middle and above unless there is some real live negotiation or competition going on.

And I think you can increase that by saying the outliers go out. Otherwise, I think they will gravitate and what you will have is this sort of upward drift. If you can say the outliers go out, I think they will give you real pricing instead of Disney World pricing or pretend or we wish it would be like this.

And I think any—part of what I said is any corporate benefits manager in corporate America who accepted the first proposal of health plans coming in would lose their job. I don't understand why smaller businesses would accept anything less. And, therefore, that is what I say when I say don't tie one arm behind their back in this thing. If you are going to make them compete with other things, then give them the power to negotiate. If you are going to give them exclusivity, make sure they are taken seriously by allowing them to throw out the outliers.

Mr. SHARP. Just one other quick question. Ms. Sailors, and I don't mean to exclude your colleague there, but, Ms. Sailors, I am trying to also understand what is the incentive for the alliance to act vigorously, competently. I mean, most individuals have a desire to do that but we know large institutions, as they grow up, tend to get more and more lax. And it sounds to me like there is an element of competition that you face in doing a good job.

Is that the case or how would you describe both in your circumstances where it sounds as if you folks are doing a vigorous, effective job, can we assure that in this set of term alliances, that will happen all across the board in this country?

Ms. SAILORS. Well, let me share an experience I had recently. We recently in Florida gathered all the boards of directors of the CHPA's together for training, for CHPA school. And it was a fascinating weekend. It was a weekend, they were all brought there at their cost. They were a variety of people who had been appointed by the Governor and the Speaker and the President of the Senate in our State legislature so they were political appointees, too.

Each board has a minimum of two benefits managers from corporation types so that there is a minimum of people who actually do have experience buying and selling health care. I looked at them and I came away from that weekend with a great deal of hope. As I looked at them and conducted a session or two with them, these people live in the communities they are going to serve. They live next door to commuters—I mean to consumers. If they mess up and don't do a good job, they are going to hear about it.

Their businesses are located in those communities. They are publicly known as sitting on those CHPA boards. They are going to hear about it from their friends, their neighbors, their relatives, and people they never even met before.

I think that is—you understand the accountability attached to public scrutiny because you are in public office. I think these people understand it, too, and on top of that, they have a real visceral sense of consumerism that I kind of liked. That may not be my best answer, but I would share with you a very human side of the equation, which is that these are human beings, they want to do right. They want to do well. And they are going to go home and face hell if they don't.

Mr. SHARP. Well, I appreciate your public accountability approach and whatnot. I just wondered if there is a way that we should build what is already built into your particular system—economic incentives which sort of bring a discipline to bear that happens in the private sector. One thing we tend in this country to admire about the private sector is that competition provides discipline. We are obviously trying to introduce discipline at one level of this system in the negotiation over pricing and quality care, to intensify the competition there, through the alliance.

And I am trying to ask myself about 5 years out, does this alliance then just become sort of a self-perpetuating—

Ms. SAILORS. Well, my guess is 5 years out, you can take another whack at it, too. I have never known anything to just sit there and be still.

Mr. SHARP. That is true. Thank you very much.

Mr. WAXMAN. Thank you, Mr. Sharp.

Thank you both very much. We look forward to working with you further as we evaluate some of these questions. Thank you.

Our last panel represents insurance agents and brokers who specialize in selling and servicing health insurance products. Sally Nelson is a professional insurance agent from South Portland, Maine. She is currently President-elect of the Association of Health Insurance Agents, which is affiliated with the National Association of Life Underwriters.

Alan Katz is a principal in a general insurance agency in Woodland Hills, Calif., and serves as a legislative chairman of the National Association of Health Underwriters. Mr. Katz is also the immediate past President of the California Association of Health Underwriters.

I want to welcome both of you to our hearing today. Your prepared statements will be in the record in full. We would like to ask you, if you would, to limit your oral presentation to no more than 5 minutes.

Ms. Nelson.

STATEMENTS OF SALLY I. NELSON, PRESIDENT-ELECT, ASSOCIATION OF HEALTH INSURANCE AGENTS, ALSO ON BEHALF OF NATIONAL ASSOCIATION OF LIFE UNDERWRITERS; AND ALAN KATZ, LEGISLATIVE CHAIRMAN, NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS

Ms. NELSON. Thank you, Mr. Chairman. Excuse my voice. I have come down with a cold this morning as I got here so I will do the best I can.

Mr. WAXMAN. Pull up the microphone so we will be able to hear you.

Ms. NELSON. How's that? Is that better? Thank you.

Let me begin by stating our strong support for health care reform. We support efforts to achieve universal coverage or at least universal access. We especially urge you to enact the insurance reforms that are included in most of the reform proposals. We agree that health insurance should be a guaranteed issue, guaranteed renewable, portable and subject to streamlined paperwork and administrative procedures.

We agree that there is a crucial need for cost containment and that steps need to be taken to achieve cost control. We also agree that full, free, fair competition is the best way to achieve cost control. We also strongly support an active role for the employer in providing health care coverage for all Americans.

Of most concern to us is the issue of buying groups. Most reform proposals envision creation of buying groups. Buying groups are intended to consolidate the market power of many individuals and employees of small businesses, streamline administrative costs, and eliminate or minimize risk assessment as a basis for issue and/or price of health insurance coverage.

We are willing to work with Congress as we worked with the legislature in California and Florida in designing and helping to implement these buying groups. But we believe that participation in these buying groups should be voluntary, as it is in California and Florida.

Of course, insurance reform rules must be applied to all insurance, whether it is purchased from a buying group or from outside the buying group. This assures a level playing field and eliminates adverse risk selection.

Buying groups should be voluntary. Voluntary buying groups assure true choice for consumers. Consumers should have the maximum amount of choice possible. For there to be a healthy level of choice available, there must be a healthy number of companies and plans offering health insurance coverage. Monopolistic buying groups could discourage companies and plans, especially small and medium-sized ones, from expending the capital required to compete, especially in a mono structure with little or no room for marketing flexibility. Elimination of large numbers of insurers will decrease consumer choice, possibly to harmful levels.

Voluntary buying groups will themselves benefit from competition. They will be more responsive, effective, and efficient in serving consumers if they know that consumers have a choice about where else to go to get their required health insurance coverage.

The employer must continue to play a key role in providing health insurance to the Nation's workers. Employers have a major stake in the health insurance coverage provided to their employees.

Most employers choose to pay all or part of their workers' health insurance premiums. All employers benefit from employees whose medical needs are well served. Thus an employer has an interest that is both financial and humane in an employee's health insurance coverage.

Voluntary buying groups provide a safety net by allowing a reformed private market to compete on a level playing field and thereby giving the buying group system time to work out any kinks that might develop.

Surely, if buying groups work as well as their designers anticipate, there will be little if any private market left due to competitive pressures. If, however, unforeseen problems develop that need to be fixed, the current system as reformed would remain in place. That is important, especially when you stop to remember that the current system, even without reform, serves over 85 percent of the population and serves them well.

Proponents of exclusive buying groups worry that under a voluntary system, private insurers could cherry pick; that is, insure the young and the healthy, leaving the old and the sicker population for the government to take care of. We believe that insurance reforms will prevent that from happening.

We believe that cherry picking should be eliminated. Therefore, we propose that all plans, not just those inside of buying group, be subject to risk adjustment and reinsurance mechanisms. This will eliminate cherry picking, and although there will be some additional administrative cost to a universal risk adjuster, that cost would be far less than the cost of the American public losing access to choice and competition as would happen under an exclusive buying group.

Finally, agents are crucial to choice. Where a consumer has choice, that consumer needs access to professional advice and guidance on how to make the best choice for each individual. Problems will remain between the insured and the insurer, and between medical providers and players.

Agents troubleshoot these problems. These tasks must be performed under the new system and the agent is the best trained and best equipped to do the job.

Madam Chairwoman, Mr. Chairman, thank you again for the opportunity to testify.

Mr. WAXMAN. Thank you very much, Ms. Nelson.

[Testimony resumes on p. 127.]

[The prepared statement and attachments of Ms. Nelson follow:]

TESTIMONY OF
SALLY I. NELSON, PRESIDENT-ELECT,
ASSOCIATION OF HEALTH INSURANCE AGENTS

Madam Chairwoman, Mr. Chairman, and members of the subcommittees, thank you for the opportunity to testify this morning. My name is Sally Nelson. I am an agent from South Portland, Maine, and currently serve as president-elect of the Association of Health Insurance Agents (AHIA). AHIA, a conference of the National Association of Life Underwriters (NALU), represents some 9,000 professional insurance agents whose primary business involves health, disability and long-term care insurance. Founded in 1890, NALU is a federation of approximately 1,000 state and local associations whose members include over 143,000 professional life and health insurance agents throughout the nation.

Agents Support Health Care Reform

NALU and AHIA members support health care reform, and applaud this committee, other members of Congress, the president and others for their efforts to rationalize the health care delivery and financing systems. Each of the reform proposals currently pending has many strengths which we urge you to consider carefully—and enact the best into law. Among the reform measures that we encourage you to adopt are so-called insurance reforms which would subject all health care plans to guaranteed issue, guaranteed renewability, portability, limits on pre-existing condition requirements, administration and paperwork streamlining, and cost control measures. We understand the need to make sure that the reformed system's costs are as contained as much as possible, and the need for government involvement, especially in the provision of health care to underserved areas and low-income people. We agree that government involvement should enhance what is essentially a

competition-driven, private system that guarantees full and free choice for all Americans. We also support an active employer role in the provision of health care coverage for all Americans.

Buying Groups Should Be Voluntary

The President's health reform proposal, along with H.R.3222/S.1579 and the Senate Republican Health Care Tax Reform proposal, makes a principal part of health care reform the creation and implementation of a "buying group." The buying groups are intended to consolidate the market power of many individuals and employees of small businesses; streamline administrative and paperwork requirements and realize substantial cost-savings as a result; and also to eliminate, or minimize, risk assessment (of individuals or small groups) as a basis for issue and/or price of health insurance coverage. In the Clinton proposal, the buying group is called a health alliance, and it would be the only way (i.e., it would be mandatory) for any individual or employer group of under 5,000 to purchase health insurance. Under the rules of H.R.3222/S.1579, the buying group is called a HPPC (health plan purchasing cooperative), with participation in the HPPC mandatory for individuals and for businesses of 100 employees or fewer. The Senate Republican plan sets up HPPCs, but makes them voluntary for all.

NALU/AHIA believe that to the extent the reformed health care delivery/financing system includes buying groups, participation in them should be voluntary. Buying groups are a

largely untested, theoretical concept that may well prove to be effective—but there is also the possibility that unforeseen problems will develop and changes will have to be made. Thus, a period of "testing" the buying group concept, without imposing unnecessary risk to the current system of health insurance coverage, becomes an important safety net. This is what the states of California and Florida did in enacting health care reform. The professional agents represented by AHIA and NALU worked with California and Florida in creating their reforms, and are working with the states' buying groups now. We want to work with the Federal government on reform as well, and also hope to be able to work with the buying groups, if they result from this reform effort.

A rule that makes participation in buying groups mandatory poses an unnecessary threat, and undercuts the safety net protection needed during the testing period. Because buying groups are built on a theory of market power derived from pooling many individuals, insurance plans must attract a large number of participants in order to compete. Because exclusive buying groups may not allow sufficient flexibility for small and medium sized insurance plans to market in such an environment, there is grave risk—indeed, a high likelihood—that due to capital requirements and market penetration concerns, many—probably most—small and medium sized insurers will be unable or unwilling to experiment in this new environment. If this happens, only a few, large insurance companies and/or provider networks will survive. This in turn will seriously undercut the safety net potential allowed by rules that permit the private sector to compete—on a fair and open playing field. It will also substantially limit the choices available to consumers of health care services.

Further, there is substantial agreement both in government and in the private sector that competition is the key to the new system. The President, the authors of the principal Congressional health care reform proposals, health care providers and health care insurers all generally agree that costs cannot be controlled without vigorous, fair competition. The truth of this belief is just as applicable to the buying groups themselves. A buying group will be more responsive, more effective, more efficient and more likely to succeed in its mission of assuring quality, affordable health care to all comers if it is itself subject to full, free, fair competition.

It is important to dwell a moment on the phrase "full, free, fair competition." Neither the insurance coverage available inside the buying group nor insurance coverage available on the private market should be subject to competitive advantages derived from regulatory issues. If plans inside the buying group must provide guaranteed issue, guaranteed renewability, portability, limits on pre-existing condition exclusions, etc.—and they should—then, so, too must plans available outside the buying group be subject to these rules. Insurance reform is a crucial element of health care reform, regardless of the structure under which health care coverage is delivered to consumers.

The level playing field requirement guarantees that buying groups will not be subject to "cherry-picking;" i.e., the practice of trying to identify the healthiest, best risks and thereby leave the less healthy people for others to insure. Some say that a voluntary buying group structure poses the risk of cherry-picking for the buying groups. Others argue that the risk

is graver for insurance available outside the buying group. Neither is an acceptable result. Cherry-picking must be eliminated for this system to work.

Thus, we would recommend that the risk adjustment/reinsurance mechanisms proposed to operate on insurance plans inside the buying group be expanded to apply to all plans, whether available on the outside or inside the buying group. Attached is a proposal, developed with technical assistance from the Health Insurance Association of America, which we believe would guarantee that fully fair and level competitive playing field that we all agree is critical to the potential for success of the buying group structure. In short, the risk adjuster/reinsurance mechanism would mathematically adjust for claims experience among all health insurance plans. It would calculate a "risk adjustment factor" to account for consumers' use of insurance coverage. That factor would be used to increase or decrease the premium charged by an insurance plan—after the period of insurance—to smooth out inevitable "bumps" in claims experience. It also eliminates any incentive to save money on health insurance by the premium payers by trying to join or form a group composed of only young, healthy participants. In short, it eliminates any benefit from cherry-picking and as a result eliminates the practice itself.

Proponents of the buying group system agree on the need for risk adjustment among plans inside the buying group. It is but a short step to acknowledgement that the concept should work just as well if applied to all plans. It is true that additional administrative work will be required. But computer capability should minimize the additional work, given that the

really tough part of the task is not the collection or analysis of the data, but rather the design of the system generating the data. That design problem remains essentially unchanged regardless of the number of plans subject to it. In addition, the extra administrative cost pales in comparison to the cost of a system that has lost the benefits of free competition due to creation of a government or quasi-government monopoly (the Health Alliance or HPPC).

Employers Should Continue to Play Vital Role in Health Care Financing

Currently, over 3/4 of all health insurance coverage is provided through employment. Most Americans and their families are covered through employer-provided (and usually paid-for, at least in part) health insurance. That crucial employer link between insurance and consumer continues under all the pending health care reform proposals. Employers are required to at least make insurance available, through the buying group at specified workforce size levels, to all their employees, and the President would require employers to pay 80% of the average, weighted premium for all their employees. Even where employers are not required to pay for coverage, they are required to allow payroll deduction of premiums paid to HPPCs to distribute to accountable health plans.

The reform proposals' recognition of the key role of employers in the health care financing system is well-placed. But it needs to focus on one additional element—employers. Whether or not employers are required to pay for health insurance premiums, they most often CHOOSE to pay at least a part of their employees' health care coverage. They have

a stake in effective, efficient health care delivery and cost. Their workers' productivity is affected, significantly, by this issue, adding yet another element to the bottom line of this country's economy from this issue. Employers must continue to be active participants in the selection process of affordable, quality health care and health care coverage. A buying group that is voluntary is the best way to accomplish this objective.

The Agent's Role in Choosing Health Care Coverage

Historically, the agency system has been the principal method of distribution for private life and health insurance. Agents are the essential link between consumer—whether individual or business—and the insurance company, providing and servicing the products of the insurer while educating the consumer on how to manage risks and how to make informed choices regarding their insurance purchases. The need for this function continues under the proposals for reforming the system. Although all plans contemplate design and provision of "basic, comprehensive" packages of coverage, there will remain choice, and where there is choice, there is the need for informed, expert guidance in making that choice. Further, there will remain a third-party payment system. Insurance, in whatever form, will be paying for the bulk of a consumer's health care costs. Thus, the need to troubleshoot between the insurer and the provider, on behalf of the consumer, will remain. Therefore, the role of the agent remains.

The agent has proven to be, in most cases, the professional most able to provide expert

guidance in making choices, as well as efficient resolution of claims or other problems between the provider and the consumer and the insurer, in the most cost-effective manner. The Managed Competition Act recognizes this with its explicit language allowing insurance plans to use agents. Even the Clinton proposal, despite its explanatory language that terms agents "outdated" and unnecessary, recognizes the need for advice and guidance in making insurance choices, especially for coverage beyond the basic, comprehensive package. Therefore, it is crucial to acknowledge that although some consumers will take the time and expend the energy to read detailed descriptions of plans and procedures, many, many more will want to be able to call upon a professional to help them sort through what is, after all, a fairly complicated and extremely important issue. We believe many consumers will WANT—and should be able—to keep working with their agents.

What does the licensed, state-regulated professional agent do?

- * Professional health insurance agents work with clients to evaluate their need for health and other insurance protection. This may involve substantial research and fact-finding about the person's individual and family situation and the available products best suited to meeting the needs of those individual situations. This is an on-going process since needs continuously change as a person's family and employment situation change.

- * Professional health insurance agents explain the various programs available and relate the elements and restrictions inherent in a given plan to the plan's costs.

- * Professional health insurance agents encourage their clients to act in a timely fashion to assure that the proper coverages are in place when they are needed. They also

see to it that accurate and complete information is provided to the insurer so that the client is sure to get the very best price or premium available.

* Professional agents keep in touch with their clients and review or update coverage on a periodic basis. They suggest changes when appropriate and counsel clients on ways to reduce cost. Often, they assist their clients in reviewing the need for legal and/or tax compliance, and recommend other professionals when assistance such as tax or legal issues arise.

* Professional health insurance agents assist with claims, answer questions and serve as ombudsmen in helping their clients deal with insurance companies and, often, with medical services providers. They help clients assemble proper documentation to file or follow up on claims, especially among those agents whose clients are Medicare beneficiaries.

* Professional health insurance agents assist business owners in communicating benefit packages to their employees, and often assist the employees in seeing how the benefits coordinate with their personal financial programs as well as those provided by government.

The helpful role agents play with small business firms was borne out by a poll (attached), commissioned by AHIA and done by Penn-Schoen this past autumn. The poll demonstrates that over 70% of small businesses who now provide health insurance to their employees like, respect and value the services they receive from their agents.

We believe that even after reform, someone will have to provide advice on how and what to choose in the way of the best health insurance coverage for each individual, troubleshoot problems between providers, consumers and insurers. Booklets, brochures, "report cards" and other documents; 800 numbers and other impersonal information sources will certainly work for some consumers. For most, such devices are simply insufficiently responsive to consumer needs. We need look only to the IRS and its documents and information telephone numbers for a lesson in how not to serve the consumer. To be truly responsive in a cost-effective way, the new system needs someone who will look out for the consumer. We believe that that someone should continue to be the someone who performs these tasks so well now: the professional, caring health insurance agent.

Tax, Cost Control, Product Design Issues Also of Some Concern

While AHIA/NALU are primarily concerned with the issue of devising the best structure for a reformed health care delivery system, we are also concerned with financing aspects of the reform plans. While we have historically supported tax incentives aimed at encouraging people to enjoy the security of adequate and appropriate insurance protection, we will not oppose provisions, such as a tax cap or an employer mandate, that go beyond encouragement and incentive, if such provisions are drafted appropriately narrowly and target accurately our mutual goal of assuring universal access to affordable, quality health care coverage.

However, we must note that insurance companies must be able to create the insurance products we all want all Americans to have. Thus, premium caps and, possibly, pricing restrictions such as pure community rating, to the extent that they make it impossible for insurance companies to offer adequate insurance products, will be a problem for the agents represented by AHIA and NALU. We support the companies in their efforts to work with government to design appropriate cost containment measures.

Madam Chairwoman, Mr. Chairman we appreciate the opportunity you have given us to testify here today and we look forward to working with you on this vital issue. For now, I would be pleased to respond to any questions that you might have.

Thank you.

Selection Issues and Potential Solutions in a Voluntary HIPC Environment

Context

A goal of many policymakers promoting health system reform is to identify the mechanisms most likely to result in cost-effective, universal and affordable access to health care for all Americans. To that end, the following information is offered to foster investigation of how to eliminate or minimize the potential for health plan or insurance carrier "cherry-picking" in a reform environment that contains voluntary HIPCs. This document should not be construed as implying support for or opposition to any of the premises on which the discussion is based.

Background

Regional "health alliances" or "health insurance purchasing cooperatives (HIPCs)" have been proposed as a key component of a comprehensive health reform strategy. Proponents claim that these purchasing pools will "give small employers and individuals the market power of large employers," reduce insurance overhead, spread risk more fairly, and provide continuous coverage for workers who change jobs frequently.

Most often, it is envisioned that HIPCs would replace the employer as the mechanism through which enrollment in a health plan is arranged. HIPCs would contract with multiple health plans serving their area and would offer individual employees (and non-employed residents as well) a choice of which plan to enroll in. Employers would continue to pay most of the health plan premium and would deduct the remainder from workers' paychecks and forward it to the HIPC; the HIPC would then pay the health plan. But most employers (except perhaps the largest) would no longer contract directly with a health plan or plans to cover their workers.

This approach is sometimes called "exclusive HIPCs" or "mandatory HIPCs." The alternative, "voluntary HIPCs," leaves it up to the employer to decide whether to use the HIPC or to contract with a health plan or insurer, either directly or through an agent or broker.

Proponents of voluntary HIPCs argue that implementing mandatory HIPCs would force millions of Americans to change long-established health insurance relationships, virtually overnight.

Such a complete restructuring of the health insurance marketplace would be a monumental, risky, and possibly chaotic undertaking, especially considering the fact that the HIPC concept has not been thoroughly tested in practice.

Establishing HIPCs for voluntary use by employers (along with other insurance reforms), on the other hand, would not disrupt the entire market. Existing insurance relationships could remain in place, at the option of the employer; but the HIPC would be available as a competitive alternative.

If the HIPC can in fact do a better job of offering affordable health insurance than the current agent/broker system, then the HIPC will have no trouble attracting clients. A voluntary system also promotes cost-reducing competition: it will encourage both HIPCs and agents/brokers to carry out their administrative functions as efficiently as possible.

Finally, there is a risk that mandatory HIPCs, being monopolies, would become bureaucratic and unresponsive to their customers; voluntary HIPCs are more likely to remain responsive and accountable, because customers have other options.

The Issue

One argument for requiring all employers (or all but the largest employers) to use the HIPC is to prevent "cherry picking" by insurers that could result in risk selection adverse to the HIPC. Proponents of mandatory HIPCs fear that, if insurers are allowed to market to employers directly (not through the HIPC), they will find ways to identify and cover healthy groups, while avoiding unhealthy groups. If this were to occur, the average premium inside the HIPC would be higher than the average premium outside the HIPC, and the HIPC would not be able to compete effectively, even if its administrative overhead was lower. The goal of community rating (having everyone in the community help to subsidize the costs of those most in need of health care) would be undercut. And, if an "adverse selection spiral" ensued, the HIPC might be doomed financially.

(Some analysts believe that, for employed populations at least, the HIPC may actually receive favorable selection. This would occur, for example, if all the health plans available through the HIPC were tightly managed network-based plans. In this situation, workers with existing health problems and, therefore, established physician relationships, might prevail on their employer to arrange coverage through a traditional indemnity-style plan outside the HIPC.)

At issue, therefore, is whether there are ways to prevent or correct for the potential selection problems associated with a voluntary HIPC structure, i.e., permitting employers to decide whether or not they want to use the regional HIPC to arrange health coverage for their employees.

Potential Solution

This brief paper outlines one way that the potential risk selection problems in a voluntary HIPC environment can be prevented or corrected for. The solution encompasses two types of reform initiatives: (1) rules of market behavior that all health plans/carriers must follow, aimed at preventing risk selection at the outset (or at least making it much more difficult to engage in), and (2) a risk-adjustment mechanism, perhaps combined with traditional reinsurance, aimed at removing any financial incentive to engage in risk selection and at compensating plans that receive more than their fair share of higher-than-average risks.

Rules of Market Behavior

Adoption of the following market rules would significantly reduce both health plans'/carriers' and employers' incentive and ability to select risks.

1. Basic accessibility rules (guaranteed issue, guaranteed renewability, no exclusion of employees from employment-based groups, limitation or elimination of pre-existing condition exclusions) apply to all employment-based health plans, regardless of size. (Extending these market reform rules to individual coverage assumes the existence of a government mandate that all individuals must have coverage; if not, modification of these rules for the individual market is required.)
2. All carriers must use the same rating methodology for all employers/ees eligible to use the HIPC, regardless of whether the particular carrier is selling through the HIPC or directly to employers. That is, all health plans/carriers must quote rates on the same basis (per single or family contract, per employee, percent of payroll) and use the same rating categories (if any rating categories are permitted).

Unless all plans rate on the same basis, employers may choose where to get coverage based on which rating methodology produces the most favorable rate for their group.

Note, however, that requiring health plans/carriers to use pure community rating creates strong financial incentives for them to select risks, because the payoff in terms of a lower, more competitive community rate is very high. One way to offset these incentives is to implement a risk-adjustment mechanism. (Discussed further below.) Another is to allow health plans/carriers to use rating factors such as: area, age, gender, family size, duration of rating period, and industry (but not health status or claims experience for HIPC-eligible groups). Doing so would reduce the incentive to select risks by preserving plans' ability to offer lower rates to demographically less risky groups.

3. Employer contribution requirements should be consistent inside and outside the HIPC, in order to mitigate any selection among plans or inside/outside the HIPC on this basis.
4. Employees must participate in an employer (group-arranged) plan for which they are eligible before being assured issuance of individual policy (inside or outside the HIPC).

This rule protects the individual and group markets in different ways. First, it assures groups that better individual risks will not leave the group. Second, it protects carriers providing individual coverage against an employer attempting to "dump" high-risk employees into the individual market to improve the risk profile of its group.

5. Marketing practices inside and outside the HIPC should be subject to the same review procedures to prevent attempts to circumvent the "no risk selection" objective. This general recommendation encompasses a number of additional points:
 - ▶ Standard cost and quality data would have to be available, regardless of whether the plan is offered inside or outside the HIPC.
 - ▶ Agent compensation should be structured so that it is not dependent on the health or claims experience of the cases written. This should diminish any incentive to "steer" particular consumers into (or out of) the HIPC.
 - ▶ The basic package(s) of benefits and cost-sharing should be the same inside and outside the HIPC.
 - ▶ Supplemental benefits must be packaged and priced separately from the basic package.
6. HIPC-eligible self-insured employers should be subject to the same market rules as insured plans, with limited modifications appropriate to the self-insured setting.
 - ▶ With respect to rating, HIPC-eligible self-insured employers must participate in a risk adjustment mechanism on an equal basis with insured plans. This requirement is necessary to protect the HIPC from possible adverse selection which could occur if lower-risk groups increasingly chose to self-insure (equivalent to experience rating). It also ensures that no insurer (including self-insurer) profits from risk selection, and that all insurers focus on management of risk to achieve appropriate, high quality, efficiently provided health care.

Risk-Adjustment Mechanism

In order to reduce the incentive to select risks and to compensate for any variations in risk that may occur, all health plans/carriers serving HIPC-eligible employers/ees should be required to participate in a risk adjustment or risk pooling mechanism.

An effective risk adjustment system will guarantee that no health plan/carrier or employer can benefit financially from attempts to select good risks. It will also compensate health plans/carriers that receive a disproportionate share of higher-than-average risks, for whatever reason. In a community-rated environment, the absence of such a system (or the use of an ineffective system) could jeopardize the financial viability of some competing health plans/carriers and, therefore, the ultimate success of a reform strategy built on competition among private health plans.

Two attachments describe one way that a risk adjustment mechanism could operate. The first (Attachment A) outlines the steps in the risk adjustment process; the second (Attachment B) uses a simplified numerical example to show how this adjustment process would work.

Each of these attachments assumes the existence of a reliable method for assessing the relative risk (expected cost) of one health plan's enrollees versus another's.¹ The availability of a reliable risk assessment method is central to the feasibility of any risk adjustment mechanism. However, it is widely recognized that currently available methods have not been adequately tested for this purpose and may be infeasible or inadequate for the task.

Risk assessment methods based on readily available demographic information about enrollees (geographic area of residence, age, gender, family size, industry of employment, etc.) could be implemented today. However, there is concern that demographic information alone may not be an adequate basis for estimating a group's future health care needs, particularly in the context of likely reforms. In the current system of insuring (whole) employer groups, the high utilization and cost of high-risk employees in the group is typically offset by the low utilization and cost of low-risk employees. In this case, the average claims experience of competing health plans/carriers is likely not to differ greatly, and the need for a refined risk adjustment mechanism is attenuated. However, most reform proposals call for individual employee choice of plan within HIPCs. It is possible that certain plans offered by the HIPC may primarily attract high-risk employees from many or all employer groups.² The need for a more refined risk adjustment mechanism is much greater in this case. Ongoing bias from a crude risk adjustment mechanism could jeopardize the viability of such plans because of adverse selection, a danger that risk adjustment is supposed to eliminate.

Considerable additional research and data systems development will be needed to arrive at a broadly accepted, implementable risk assessment method for use in the risk adjustment process. Other arrangements may be needed in the interim.

Interim Measures

Until a more reliable risk assessment method is available, interim policies may be needed to mitigate the risk of health plans/carriers failing due to adverse selection. Possible options might include, for example:

- the use of modified community rating rather than pure community rating for HIPC-eligible employers/ees (as suggested above);

¹ The desirable attributes of an acceptable risk assessment method include: accuracy, predictability, practicality (reasonable cost), understandability, timeliness, and resistance to gaming.

² For example, plans that allow greater patient choice of provider may tend to attract people with existing medical conditions. Such people are more likely to have existing provider relationships that they are unwilling to break, and their possibly multiple providers may not all participate in the same network-based plan. In an individual-choice environment, where a health plan is not assured of covering an employer's whole group (the low-risk employees as well as the high-risk employees), plans offering freer choice are potentially at risk of experiencing severe adverse selection.

- broad-based reinsurance to protect plans which experience a disproportionate share of high-cost catastrophic cases;
- specifying that the HIPC enroll its members in participating health plans on an employer-group basis, rather than on an individual basis. (As noted above, enrolling groups rather than individuals reduces the degree of adverse selection to which plans/carriers are exposed.) An adequately effective risk assessment method may be easier to develop in a group-choice environment, in which the higher risk of some group members is offset to some extent, even in the smallest groups, by the lower risk of other group members.

Other Subsidization Issues

This paper addresses in detail only risk selection issues within the employed population. If the HIPC is used as the vehicle for providing health coverage to non-employed individuals and families, such as Medicaid recipients or early retirees, then other cross-subsidization issues arise: The non-employed are, arguably, less healthy and more costly than the employed; and they are unlikely to have sufficient income to pay even a standard premium out of their own pockets.

But the subsidies necessary to provide coverage to the non-employed population are essentially separate from the issue of risk selection within the employed population. The non-employed can readily be treated as a separate rating pool within the HIPC, with a separate rate. Then the total subsidy necessary to pay for their care can be easily calculated, and a determination made about what is most appropriate funding source.

How Risk Adjustment Might Work in a Voluntary Purchasing Pool Environment

Steps in the Risk Adjustment Process

The following scenario illustrates one way in which "risk adjustment"³ might work across all health plans in a market area. The example assumes that small employers may purchase basic coverage directly from health plans, or they may arrange for coverage through a purchasing pool (regional health alliance or HIIP). All health plans, whether selling to individual employees through a purchasing pool or to employers outside the pool, are subject to uniform rating requirements and other regulations pertaining to basic benefit coverage.

Additional assumptions include:

- ▶ Employers and employees are required to purchase coverage for the basic plan.
- ▶ Each health plan/carrier quotes a flat community-rated premium for basic benefit coverage which is the price each individual enrollee must pay. The community-rated premium could alternatively be calculated per employee (primary insured).
- ▶ For simplicity, we describe an annual risk adjustment process, assuming there is no entry into or exit from plans during the year. In reality, the adjustment process would take place more frequently to address differing enrollment periods and other enrollment changes during the year.
- ▶ This example addresses only risk selection issues within the employed population. The subsidies necessary to provide health coverage to non-employed individuals and families are essentially a separate issue.

In this example, the entity overseeing the risk adjustment process is simply called the "risk adjustment administrator" (RA Administrator). The function of overseeing the risk adjustment process could be performed by a state agency or board, a state or regional purchasing pool, a private-sector enterprise, or some other organization.

³ In the context of health reform, the term "risk adjustment" refers to a process of transferring (redistributing) premium income among health plans in a market area. Risk adjustment is needed in a reformed insurance market whenever rating restrictions prevent plans from charging premiums that reflect the expected costs the plans will incur.

We first describe the sequence of events in the risk adjustment process. We then present a simplified numerical example of the rate adjustment and revenue transfer calculations which are part of the process.

Sequence of Events

Step 1 Health plans/carriers register with the RA Administrator.

- Several months before enrollment begins, all health plans/carriers who wish to sell coverage for basic benefits in the market area in the coming year must register with the RA Administrator, and must indicate whether they plan to sell this coverage through the purchasing pool or directly to small employer groups.
- As a condition, they must agree to all market rules, including participating in the risk-adjustment process (discussed earlier).

Step 2 The RA Administrator provides the information each health plan/carrier needs to develop its "standardized" community rate.

The RA Administrator provides each plan/carrier with 3 standard pieces of information which the administrator will use in calculating revenue transfer amounts for each plan:

- definitions of the risk classification categories;
- the "relative risk factors" for each risk category; and
- the reference premium amount upon which the transfer amounts will be based. The reference premium could be last year's average premium in the community trended forward, or any another designated amount.

Step 3 Each health plan/carrier develops its standardized community rate for the coming year.

- Development of the plan's/carrier's "standardized" community rate starts with the community rate it would charge in the absence of a risk adjustment process. Adjustments are then made considering expected transfer payments and other contingencies associated with risk adjustment.

- Plans are free to use whatever method they choose to develop their standardized community rate. A plan may choose to use the information supplied by the RA Administrator (step 2) to calculate its expected transfer amount, and to adjust its community rate by the transfer amount. The rate would be adjusted upward if the plan/carrier expects to have to pay into the transfer pool, and downward if it expects to receive money from the transfer pool.

- Each plan/carrier may choose to further adjust its rate for pricing uncertainties associated with the risk adjustment process.

- The end result is the plan's "standardized" community rate, the rate enrollees (or their employers) will actually be charged for enrollment in the plan.

Step 4 RA Administrator publishes rates.

- The plans report their standardized community rates to the RA Administrator.
- The RA Administrator publishes the rates well before enrollment begins, together with information about whether the plan/carrier is marketing inside or outside the purchasing pool.

Step 5 Enrollment.

- Health plans/carriers market either directly to small employers, or to individual employees purchasing through the pool.
- Small employers evaluate options and decide to purchase coverage directly, or through the purchasing pool.
- Individual employees (inside) and small employers (outside) choose their preferred plans.

Step 6 Health plans/carriers report actual enrollment data to the RA Administrator.

- Plans/carriers selling inside the purchasing pool (HIPC) receive enrollment information from the pool administrator.
- All plans/carriers report to RA Administrator their total enrollment and distribution of enrollees by risk category.

Step 7 RA Administrator calculates transfer amounts and administers revenue transfers.

- The RA Administrator calculates each plan's/carrier's revenue transfer amount, based on the plan's/carrier's actual enrollment, the relative risk factors and the reference premium.
- For plans/carriers which must pay into the transfer pool (plans/carriers with actual relative risk lower than the community average), the RA Administrator bills the plan/carrier for the transfer amount.
- The RA Administrator pays out the transfer amounts to the plans/ carriers which receive money from the transfer pool (plans/carrier which have actual relative risk greater than the community average).
- Theoretically, the risk adjustment process aims for a zero balance in the transfer pool in each period – transfers in should equal the transfers out. In practice, neither the plans/carriers nor the RA Administrator have perfect knowledge, and there may be changes in total enrollment and enrollee distribution by risk class in the community during the year. To ensure that the transfer pool has sufficient funds (remains solvent), the transfer amounts could be adjusted, or another source of funds could be tapped to create a reserve upon which the transfer pool could draw if needed.

Attached (Attachment B) is a simplified numerical example of how this risk adjustment process would work in practice.

How Risk Adjustment Might Work in a Voluntary Purchasing Pool Environment

A Simplified Numerical Example

NOTE: This example is intended solely to illustrate the steps in the risk adjustment process described above. Other approaches to risk adjustment are possible. Further, the risk categories and assigned relative risk factors used here are arbitrary and purely illustrative.

Step 1 Health plans/carriers register with the RA Administrator.

Three health plans/carriers register with the RA Administrator: Plan A, Plan B, and Plan C. These are the only plans/carriers in the community (offering basic benefit coverage), and together they cover all 20,000 members of the community.

Step 2 The RA Administrator provides the information each health plan/carrier needs to standardize its community rate.

A. Risk categories.

The RA Administrator tells the health plans/carriers there are three risk categories, defined by eye color:

Category Definitions

- Category 1 = brown eyes
- Category 2 = blue eyes
- Category 3 = hazel eyes

B. Relative risk factors.

The RA Administrator tells the plans/carriers the relative risk factors for each category:

Relative Risk Factors

- Category 1 - 0.6
- Category 2 - 0.8
- Category 3 - 1.6

C. Reference premium.

The RA Administrator tells the plans/carriers that the reference premium for calculating transfer amounts is \$200. The reference premium can be fixed at any reasonable amount. One choice could be the RA Administrator's estimate of last year's average cost per person for the community as a whole, trended forward. Another option is an estimate of the average cost per person of the more efficient plans/carriers.

Step 3 Each health plan/carrier develops its standardized community rate for the coming year.

NOTE: Plans will in fact, use whatever method they choose to develop their "standardized community rate," which is the rate enrollees or their employers will actually be charged for enrollment in the plan. (We ignore here any mark-up the HIPC might add to fund its operations.) This example illustrates one way the plans might approach developing their standardized community rates.

A. Expected enrollment.

The three plans/carriers expect the following enrollment:

Expected 1994 Enrollment (number of enrollees)				
Plan	Brown Eyes	Blue Eyes	Hazel Eyes	Total
A	2000	5000	1000	8000
B	1000	3000	2000	6000
C	1000	2000	3000	6000
Whole Community	4000	10,000	6000	20,000

B. Unadjusted flat community rate.

Based on plan historical experience, expected medical inflation, etc, plan/carrier actuaries calculate the flat community rate the plan/carrier would charge in the absence of rating restrictions for the expected enrollment (expected risks). We call this the "unadjusted" community rate.

Unadjusted Community Rate

Plan A - \$190

Plan B - \$210

Plan C - \$240

C. Plan/carrier expected relative risk (average risk relative to whole community)

Based on the enrollee category relative risk factors supplied by the RA Administrator, plan/carrier actuaries calculate the plan's expected relative risk. The average risk for the whole community is 1.00.

The expected relative risk is a weighed average of the category relative risk factors, where the weighs are the proportion of enrollees expected in each category.

$$\text{Plan A: } (2000 (0.6) + 5000 (0.8) + 1000 (1.6)) / 8000 = 0.85000$$

$$\text{Plan B: } (1000 (0.6) + 3000 (0.8) + 2000 (1.6)) / 6000 = 1.03333^*$$

$$\text{Plan C: } (1000 (0.6) + 2000 (0.8) + 3000 (1.6)) / 6000 = 1.16667$$

* rounded

Expected Relative Risk

Plan A - 0.85000

Plan B - 1.03333

Plan C - 1.16667

D. Expected transfer amounts per enrollee.

Each plan's expected per enrollee transfer amount is equal to:

(1 - plan's expected relative risk) (reference premium)

$$\text{Plan A: } (1 - 0.85000) (200.00) = 30.00$$

$$\text{Plan B: } (1 - 1.03333) (200.00) = - 6.67$$

$$\text{Plan C: } (1 - 1.16667) (200.00) = - 33.33^*$$

* rounded

Expected Transfer Amount

Plan A - \$30.00

Plan B - (\$6.67)

Plan C - (\$33.33)

E. Developing standardized community rate.

Each plan's/carrier's standardized community rate equals its unadjusted community rate plus the expected transfer amount, further adjusted for other contingencies. In this example, we do not include an adjustment for other contingencies.

$$\text{Plan A: } \$190 + 30.00 = \$220.00$$

$$\text{Plan B: } \$210 - 6.67 = \$203.33$$

$$\text{Plan C: } \$240 - 33.33 = \$206.67$$

Standardized Community Rate

Plan A - \$220.00

Plan B - \$203.33

Plan C - \$206.67

These are the rates that each plan/carrier charges per person enrolled.

Step 4 RA Administrator publishes rates.

Step 5 Enrollment.

Step 6 Health plans/carriers report actual enrollment data to the RA Administrator.

The plans/carriers report the following enrollment:

Actual 1994 Enrollment (number of enrollees)				
Plan	Brown Eyes	Blue Eyes	Hazel Eyes	Total
A	1000	3000	1000	5000
B	1500	4500	2500	8500
C	1500	2500	2500	6500
Whole Community	4000	10,000	6000	20,000

Step 7 RA Administrator calculates transfer amounts and administers revenue transfers.

A. Actual relative risk.

RA Administrator calculates each plan's/carrier's actual relative risk:

The actual relative risk is a weighted average of the category relative risk factors, weighted by the actual proportion of enrollees in each category.

$$\text{Plan A: } (1000 (0.6) + 3000 (0.8) + 1000 (1.6)) / 5000 = 0.92000$$

$$\text{Plan B: } (1500 (0.6) + 4500 (0.8) + 2500 (1.6)) / 8500 = 1.00000$$

$$\text{Plan C: } (1500 (0.6) + 2500 (0.8) + 2500 (1.6)) / 6500 = 1.06154$$

* rounded

Actual Relative Risk

Plan A - 0.92000

Plan B - 1.00000

Plan C - 1.06154

B. Transfer amounts.

The transfer amount for each plan/carrier is calculated according to the following formula:

$$\text{Transfer Amount} = (1 - \text{plan actual relative risk}) (\text{reference premium}) (\# \text{ enrollees})$$

$$\text{Plan A: } (1 - 0.92000) (\$200) (5000) = \$80,000$$

$$\text{Plan B: } (1 - 1.00000) (\$200) (8500) = 0$$

$$\text{Plan C: } (1 - 1.06154) (\$200) (6500) = (\$80,002)^*$$

* transfers do not add to \$0 because of rounding.

C. Revenue transfers.

The RA Administrator instructs Plan A to pay into the pool \$80,000. The RA Administrator then pays out \$80,002 to Plan C. Plan B, in our example, transfers neither in nor out.

Summary Report on national opinion survey of small businesses concerning health care issues

Small businesses want the right to choose between all options now available in the health care marketplace and any innovations, such as purchasing groups, that may come into existence. Better than three in four (77%) small businesses that offer their employees health insurance say that there should be both purchasing groups and a private insurance market that compete on a level playing field. Small business people see this as the best guarantee that cost savings, if any, will be realized from health care reform, and that the levels of service they now enjoy are preserved.

Small businesses are unconvinced that innovations such as purchasing groups will work as intended and that competition can actually be managed. For example, 43% say group purchasing power will mean less affordable coverage for small businesses, while 39% say that group purchasing power will make coverage more affordable for small businesses. Small businesses sense that health care reform means more costs and concerns than changes for the better. About two in three – 66% – say the burden for small businesses will increase with the Clinton Administration's health care reform plan. (Only 8% say the burden will decrease.) These underlying attitudes explain why small businesses that now offer health insurance so strongly oppose requiring participation in purchasing groups. Better than eight in ten (83%) small businesses oppose the government requiring small business participation in purchasing groups.

Concerns about service/role of agents

Small businesses also worry that purchasing groups will not provide the same level of service they now get from agents or brokers. Specifically, better than three in four small businesses (78%) say agents or brokers are the most important way most of them now get detailed information about health insurance. An 84% majority of those small businesses that make use of agents say that they provide useful services, such as analyzing options in the marketplace, negotiating the plan renewal, or tailoring the plan to fit their needs. Overall, a 79% majority say that agents should continue to serve as links between insurers and the insured.

Choice between different types of health care plans

Small businesses also want the right to choose between as many different types of health care plans as possible to ensure there is always an option that fits their particular needs. About two in three (66%) say they want many different benefit plans to choose from, rather than trusting the purchasing group to provide a few basic packages meant to fit all small businesses (29%). Small businesses with a gross income between \$1-5 million are even more concerned than other small businesses that there may not be options tailored to their needs.

Strong support for reform/attitudes toward taxation

Small businesses now providing health insurance strongly support many proposed reforms of the health care system. For example, nine in ten (91%)

favor malpractice and tort reform. Another 86% support eliminating unnecessary medical procedures. Better than seven in ten (71%) favor caps on employer obligations for health care. If implemented by the Clinton Administration, these reforms would meet with strong approval from this segment of the small business community. Finally, about one in three (35%) small businesses that offer health insurance favor taxing employers who do not offer it to help pay for health care reform. Another 30% say they support a VAT or national sales tax to pay for reform.

The findings

The following is a more detailed question-by-question analysis of the national survey of 410 small businesses that provide health insurance.

Type of insurance

Small businesses offer a wide variety of insurance plans, and no one type predominates over the rest. About three in ten (31%) say they offer Blue Cross/Blue Shield, while 24% offer HMOs. Sixteen percent have commercial insurance, while 13% offer PPOs or preferred providers. Nine percent are self-funded.

Table 1
Type of insurance plan

Blue Cross/Blue Shield	31%
HMO	24%
Commercial Insurance	16%
PPO	13%
Self-insured	9%

Health insurance restructured or otherwise changed

Many small businesses in the United States have changed or restructured their employee health insurance plans in the last few years. Four in ten (40%) have increased employee deductibles, while one in four (25%) have adopted a flexible benefits program ("Cafeteria" style). About one in five (21%) of small businesses that offer health insurance have changed to an HMO, and 18% to a PPO. About one in eight small businesses (12%) have become self-funded.

Most small businesses (55%) have their employees contribute to the health plan. Of those businesses with employee contributions, many (44%) have increased the employee contribution in recent years. Better than seven in ten (71%) of those businesses that have increased the contribution recently raised the employee contribution 25% or less.

Other changes to make health care more affordable

We asked an open-ended or verbatim question to learn if there were any other changes that small businesses had made to make health care more affordable. About one in five had either changed carriers, shopped around for a better price, or learned more about their options in the market place to make health care costs more affordable.

Small businesses get information on insurance from agents

We evaluated various ways small businesses in this country get information on insurance ("Is this a very important, somewhat important, not very important, or not at all important way to get detailed information about your employees' health care plan?") The most important way to get information is through a health insurance agent or broker. Better than three in four (78%) say this is an important way to get information. Fifty percent say agents are "very important". Only one in five (20%) say agents are not an important way to get detailed information.

The next most important way to get information is handouts or other materials that insurers provide – 72% say it is an important way to get information about health insurance. (Twenty-nine percent say handouts are "very" important for informational purposes, while 43% say handouts are "somewhat" important.) A 65% majority say that a toll-free 800 number is an important way to get detailed information. ... Direct mail from insurers tends to be the least important way to get information, with 34% who say direct mail is an important way to learn the details.

Feature of current plan employees like best

We asked an open-ended or verbatim question to determine which feature of the current plan small employees report that they like best. One in five (20%) like being covered or aspects of their coverage ("coverage," "coverage is good once deductible is met," "additional dental," etc.). Other common responses concerned the lack of paperwork (9%), flexibility (7%), and prescription coverage (6%).

Provision of specific services by agents/brokers

A 72% majority of small businesses that now provide health insurance say agents are important for the information they provide. Another 9% say that the information they provide is not very important, while 18% say the information is not at all important. The following is an evaluation of the service provided by agents in terms of specific tasks. (The 18% who say the information is not at all important did not evaluate agents on these tasks.)

Table 2
Did agent/broker provide this service?

Specific task	yes	no
Analyze options in market	82%	16%
Negotiate renewal	75%	23%
Review and deliver contracts	73%	24%
Tailor plan to make it fit employees' needs	73%	25%
Handle enrollment and claims	69%	29%
Meet or talk to employees about plan	65%	34%
Make changes or modifications in plan	54%	43%
Advise business owners on employee contribution	54%	41%
Monitor claim experience	51%	37%
Help you with various gov't forms, paperwork	39%	53%

We also asked respondents to evaluate their agents performance on each task outlined above. Between 91% and 96% of small businesses say their agent did a good job on any particular task.

If no agents, what would your business do?

A 52% majority say that their small businesses would need to make adjustments if there were no agents or brokers. Four in ten (40%) say they could provide the same service if there were no agents or brokers. The solution for many small businesses would be to hire someone to do many of the same

things that agents do now. Better than one in three (35%) say they would hire a consultant to do what agents handle now. Another 26% would either expand the department in their business that handles health care now or create a new department (13%). Of the nearly six in ten small businesses that would need to make changes of some type or another, 53% say they would not need to hire anyone new, while 36% say they would hire one person, and eight percent say they would hire two or more people to compensate for the work now performed by the agent.

Agent compensation

Half of all small businesses do not know how much the commissions are for health insurance agents (50%). Another 38% say the commission is between 1%-10% percent, while another 10% say the commission runs between 11%-20%. Once we inform respondents that commissions average between 4%-6%, almost two in three (67%) say the price is fair. Twenty-three percent say the price is unfair.

Perceptions of managed competition

We examined whether small businesses believe that health care reform by the Clinton Administration will mean a greater or lesser burden on them. We also examined attitudes among small business in America toward purchasing groups, and some of the possible effects this critically important aspect of managed competition will have in terms of providing health insurance.

Clinton program: perceived burden on small business

Almost two in three (66%) say the Clinton Administration will put more of a burden on small businesses. About one in twelve (8%) say the burden will lessen. While majorities of small businesses of every size say the burden will increase, those businesses that employ 51-100 persons are especially likely (79%) to be concerned about new burdens. Businesses with self-funded health insurance (75%) are also more likely to say there will be a greater burden.

Prefer voluntary participation in purchasing groups

Better than eight in ten (82%) small businesses that now offer health insurance oppose the government requiring small business participation in purchasing groups. Another 13% favor requiring participation in purchasing groups. While majorities of small businesses of every size say they oppose required participation in purchasing groups, those businesses that employ 51-100 persons are less likely to support the mandatory concept (9%) than businesses with 10 or fewer employees (20%).

Prefer many different plans to choose from

Small businesses prefer (66%) to have many different benefit plans to choose from, rather than trusting the purchasing group to provide a few basic packages (29%). Those small businesses that gross less than \$5 million are concerned that a more limited set of options will not fit their particular needs. For example, seven in ten (70%) small businesses with a gross income between \$1-5 million prefer choice, and 22% say a basic package is acceptable. Small businesses that gross more than \$5 million annually are somewhat more comfortable with the idea of a few basic health care options provided by a purchasing group. (Though a majority still oppose the concept of a few basic health care packages to fit all small businesses.) Forty-two percent of those businesses that gross more than \$5 million favor a basic package, while 56% prefer to have many different plans to choose from.

Purchasing groups will not provide service agents do now

Small businesses also say the purchasing groups will not provide the same level of service that agents provide now. Fifty-nine percent say that purchasing groups will provide worse service than agents, while 17% say purchasing groups will be able to provide better service. Another 11% volunteer that the level of service will probably be about the same. Small businesses that gross between \$1-5 million annually are more likely (67%-12%) to say that purchasing groups would not provide better service than agents. The small businesses with gross incomes over \$5 million agree (55%-28%), that purchasing groups would not provide better services.

Uncertain whether group purchasing power means lower prices

Small businesses are split on the idea of whether group purchasing power will actually mean more affordable coverage or not. About four in ten (43%) say purchasing groups will mean less affordable coverage, while 39% say purchasing groups mean more affordable coverage. Four percent volunteer that it will mean no change in prices. Businesses with fewer than 10 employees are more likely (47%-29%) to say that a purchasing group will mean more affordable coverage. Businesses with more than 50 employees are more likely to say that there will be less affordable coverage (48%-33%). Rural companies are also more likely (51%-31%) to say coverage will be less affordable because this arrangement will mean less competition in the private insurance market. Southern small businesses (47%-30%) are also more likely to say there will be less affordable coverage, while Northeastern firms (45%-35%) are more likely to say there will be more affordable coverage.

Ideas for reform

We tested various ideas for reforming the nation's health care system to learn about the attitudes and concerns of small businesses nationally that already provide health insurance to employees.

Table 3
Ideas for reform

Type of reform	agree	disagree
Malpractice, tort reform	91%	5%
Eliminate unnecessary medical procedures	86%	8%
Wellness programs	87%	12%
Agents as link	79%	17%
Level playing field with both private insurance and purchasing groups	77%	17%
Caps on employer financial obligation	71%	24%
Employee/employer partnership to pay costs	66%	30%
Gov't subsidies for low-income employees to ensure basic health care	62%	23%
Reduced tax deductibility	40%	52%

Tort reform/Eliminate unnecessary medical procedures

Better than nine in ten businesses agree that malpractice and tort reform are important to cut the cost of litigation associated with health care. A 91% majority agree, while 5% disagree. Eighty-six percent of small businesses say eliminate unnecessary procedures. Eight percent do not see this as a major part of the reform process.

Agents as links/Level playing field

Seventy-nine percent say that agents should continue to serve as links between insurers and the insured. Seventeen percent disagree. Better than

three in four (77%) small businesses that now offer health insurance to their employees say that there should be both purchasing groups and a competitive private insurance market on a level playing field. Seventeen percent disagree.

Wellness

Better than three in four (77%) say tax incentives for wellness programs and other prevention programs should be part of health care reform. Twelve percent disagree.

Caps on employer financial obligations

Seventy-one percent say that there should be caps on employer obligations for health care, while 24% disagree.

Partnership between employer and employees so each pay part of the cost of health care

Almost two in three – 66% – favor a partnership between employers and employees in which both would be required to pay the cost of health care coverage, subject to the ability to pay. Thirty percent disagree.

Subsidies to ensure basic health care for everyone

Better than six in ten (62%) businesses favor government subsidies for low-income employers and employees to ensure everyone has some basic health care.

Oppose reduced tax deductibility of health insurance benefits

More than half (52%) oppose the idea of reduced tax deductibility of health insurance benefits, while 41% favor a reduction to help pay for health care reform.

Taxes

If there must be new and higher taxes, small businesses favor either taxes on employers (35%) who do not now provide health care or a VAT/sales tax (30%). Sixteen percent volunteer "no taxes" when asked this question.

Owner or employee benefit person

Almost three in four (74%) small business persons interviewed are employee benefit or other employees primarily responsible for employees' health insurance. Twenty-six percent are owners.

Mr. WAXMAN. Mr. Katz.

STATEMENT OF ALAN KATZ

Mr. KATZ. Mr. Chairman, Madam Chairwoman, health insurance agents have a unique view of the health care reform debate, because health insurance agents see every day firsthand what is working in the current system and what needs changing. That is why the National Association of Health Underwriters developed a comprehensive reform package called real choice. Its goal: To provide universal access to affordable health care through a stable and fair marketplace.

It has much in common with several congressional proposals and with the Clinton administration package. It changes the way carriers do business, requiring them to manage risk, not avoid it. It reduces paperwork and contains costs. These similarities and others are described in written detail in the written testimony. I would like to discuss two of the issues where we differ with the administration, starting with the issue of exclusive Health Alliances.

For the record, Health Underwriters questions the necessity of government-sponsored purchasing pools. However, we appreciate the desire of members of both parties to experiment with such arrangements. The issue is if there are to be Health Alliances, should they be the exclusive source of health care coverage available in a State or region?

Health Underwriters believes that voluntary Health Alliances competing on a level playing field with private carriers and private Health Alliances will serve consumers better. Exclusive Health Alliances, freed from competitive pressures, lack the incentives to provide the quality service and performance American consumers have the right to demand.

Exclusive Health Alliances are the equivalent of the company store that leaves consumers with no viable alternative but to take what they get. That is one reason why the Jackson Hole group, which originally supported exclusive Health Alliances, now reject them.

Health Underwriters also recognizes that Health Alliances are experimental. They may not work. If Health Alliances must compete with private carriers, then consumers cannot lose; whichever model works best, consumers come out ahead. However, if this Congress establishes exclusive Health Alliances and if those Health Alliances fail, an entire infrastructure will have been dismantled.

Exclusive Health Alliances represents health care reform without a net, and the folks who could get hurt the most by a fall are American consumers. These are among the reasons that seven of the eight Health Alliances that States have enacted laws to create are voluntary in nature.

Health Underwriters disagrees with the administration as to the role of agents in a reformed system. They seem to view us as part of the problem. Not surprisingly, we view ourselves as part of the health care reform solution. We do not believe that an 800 number or government manual can replace the hands-on, personalized advice and independent advocacy that agents provide their clients. For millions of small businesses, we are the only Human Resources Department they can afford.

Further, agents primary loyalty is to consumers. If we don't deliver, our clients can fire us at any time. The same cannot be said for the employees of an exclusive Health Alliance.

Eliminating agents does not eliminate the need for the services that we provide. Consumers will still have questions and they will still have problems. The issue is will answers and solutions be provided by an agent that knows the consumer, and that is accountable to the consumer, or by a full-time alliance employee who has never met the consumer and owes them no loyalty?

In California, employers are voting with their pocket books in favor of agents. As of information I received last night, which is an update from what was in my written testimony, 6 of the nearly 1,200 small businesses that have signed up with the State's voluntary Health Alliance, 79 percent close to use the services of an agent, 79 percent, even though doing so adds an average of 5 percent to the premiums they must pay every month.

Health insurance agents can play an important role in passing meaningful, comprehensive health care reform during this Congress. Agents are active in communities throughout this country. We coach Little League teams and chair the PTA, we are active in our churches and temples. We are presidents of chambers of commerce, we are on city councils and school boards.

Health insurance agents can reach out to literally millions of Americans, our clients and their employees. The professionals that make up Health Underwriters stand ready to use these positions of influence and our insight into the system to work with you and the White House to resolve our differences and achieve health care that not only is always there, but health care reform that always works.

I would be happy to take any questions you might have.

[Testimony resumes on p. 147.]

[The prepared statement of Mr. Katz follows:]

TESTIMONY
of
ALAN KATZ

LEGISLATIVE CHAIRMAN
NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS

PRINCIPAL
CENTERSTONE, INSURANCE & FINANCIAL SERVICES, INC.
LOS ANGELES, CA

before the
Subcommittee on Health and Environment
and the
Subcommittee on Commerce, Consumer Protection and Competitiveness
Energy and Commerce Committee

Mr. Chairman, Madam Chairman, Mr. Bliley, Mr. Stearnes, Members of the Committee, I thank you for the opportunity to appear before you today to discuss the Administration's proposal for health care reform, particularly the issues surrounding the proposed regional health alliances.

My name is Alan Katz. I am a principal in a general agency in California specializing in the health insurance market. In addition, I am Legislative Chairman of the National Association of Health Underwriters (NAHU), a member of the NAHU Board of Trustees, and Immediate Past President of the California Association of Health Underwriters (CAHU). With almost 15,000 members, NAHU is the largest and the only independent association representing insurance professionals specializing in health insurance in the United States. Our members are the link to health security for more than 119 million Americans.

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Our nation faces a unique opportunity to reform our health care system, an opportunity made possible through the leadership of President Clinton. The President and the First Lady deserve credit for placing health care reform at the top of our country's agenda. They also deserve credit for advancing the cause of universal access to affordable health coverage, a goal NAHU strongly supports.

NAHU supports the bulk of the President's plan and looks forward to a constructive debate. We are confident that we can resolve those points of disagreement -- most significantly the nature and structure of the alliances which are the subject of this hearing -- and achieve in the near future, meaningful health care reform that works for the American consumer.

NAHU has long supported comprehensive market-based reform of the health insurance market. We developed our position after years of experience when, as consumer advocates and advisors, we were forced to inform our clients that their health coverage was canceled; or that it would no longer be affordable; or worse, that we could not find coverage suitable to their needs.

The debate over uninsurable and underinsured Americans is not only a matter of statistics for us: we personally work with these individuals on a daily basis to obtain affordable coverages. They are not just our clients: they are members of our community, our friends, our neighbors, and in many cases, our families. Sometimes -- too many times for us -- we come up short. Agents believe in reform.

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NAHU believes there is much that is good about America's system of health care coverage today. What works now should be maintained. What doesn't work must be reformed. NAHU is committed to comprehensive and responsible health care reform providing universal access to affordable, high quality options in a competitive health care system.

Since the 1980's, NAHU has been on record in favor of market-based reforms that will achieve the six principles of reform that President Clinton has put forward: security, simplicity, savings, choice, quality and responsibility. We have repeatedly offered our strong support for these principles.

Our early commitment to reform evolved into NAHU's comprehensive *Strategy for Health Care in America*, first developed in 1990. In light of the continuing need for health reform, that *Strategy* was revised in May of 1993 and re-introduced into the reform debate as *REAL CHOICE*, a comprehensive strategy for health reform. *REAL CHOICE* is based on the NAHU's *Consumer Bill of Rights*, and copies of both are appended to my statement.

NAHU's PLAN v. THE CLINTON PLAN

NAHU's plan, like the Administration's plan, proposes universal coverage for all Americans. Under the Administration's approach, exclusive government-sponsored health alliances would negotiate with carriers to offer coverage in a region or state. Consumers employed in firms of less than 5,000 employees (and many in larger firms) could purchase their coverage only through their one local health alliance.

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The nature of the exclusive health alliances included in the Administration's legislation is somewhat less restrictive than originally proposed in September. NAHU applauds this move towards more competition, but we urge them to move further still. As representatives of the Jackson Hole group noted in testimony (reversing the group's previous position) before the Senate Labor and Human Resources Committee on October 20, 1993, the absence of competition between alliances will almost inevitably lead to a highly bureaucratic organization with a tendency to serve its own interests rather than those of its members.

NAHU's plan places greater reliance on competition. NAHU calls for a system of multiple private alliances, voluntary in nature, all competing in a well-regulated market that features a level playing field. If alliances compete on a level playing field with existing carriers and *succeed*, consumers will win. If alliances compete and fail to match the efficiencies of the private marketplace, *consumers will still win* because the reformed marketplace has met their health coverage needs. The marketplace should decide the effectiveness of this new mechanism for the time-proven concept of pooled purchasing power.

NAHU also differs with the Administration with respect to the standard benefits package. The Administration's "one-plan-fits-all" approach eliminates consumer choice and places the government in the paternalistic role of determining what consumers want and need from their health plans. It also will result in tremendous political battles over what is in the plan -- and what is not.

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NAHU believes that Americans should determine the plan design that best fits their families' needs. Instead of creating a standard plan for all Americans, we propose defining an essential benefit package that all plans must include, while permitting carriers the flexibility of adding additional benefits to meet market demand. To achieve the President's principle of simplicity, common definitions of benefits could be established so consumers could easily understand what their premium dollars are buying.

Under both the Administration's and NAHU's plans, companies would be permitted to fully deduct the cost of their plans. However, under NAHU's plan, employer-provided benefits beyond the essential benefit package would be considered taxable income to employees. This is aimed at controlling costs and encouraging responsible consumer purchasing decisions.

An additional area of contrast comes in the context of mandating coverage. The Clinton Administration proposes to build on today's predominantly employer-based system to require employers to pay 80% of the cost of coverage (within limits) for each employee and dependent.

NAHU also builds on the employer-based system by requiring employers to offer, but not to pay for their employees and employees' dependents' coverage. Instead, NAHU's plan would require individuals to purchase coverage. Subsidies in the form of refundable tax credits or vouchers would be available to assist low or moderate income individuals. NAHU proposes a full subsidy for up to 200% of the poverty level (about \$28,000 for a family of four) and a partial subsidy for up to 250% of the poverty level.

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Both plans would require comprehensive carrier reform. Both plans require guaranteed access, guaranteed renewability, and fully portable benefits for every American.

It is worth noting that 31 states have already enacted guaranteed access provisions and 44 states have enacted provisions promoting portable benefits. These state reform efforts are benefiting consumers throughout this country and should be encouraged in those states that have not yet enacted market reforms.

NAHU and the Clinton Administration also agree on the need to reduce paperwork. Both plans standardize claims and applications forms, and would move towards paperless transactions.

One area of significant difference between NAHU and the Administration is price controls. Under the Clinton plan, if spending exceeds targets, caps on spending would be implemented.

Although insurers and providers would also be adversely affected by price controls, we fear consumers stand to lose the most under caps or global budgets. With respect to the Clinton proposal, "health security" or "health care that is always there" is undermined if access to care is rationed, and simplicity is sabotaged when incentives for gaming the system come to dominate. In addition, price controls in other areas of the economy failed to work for former Presidents Nixon and Carter; there is absolutely no reason to assume that they will work now. Market-based incentives are more likely to control costs than price caps.

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Finally, the Clinton Administration and NAHU differ dramatically on the appropriate role of the professional agent in the health care system. The Administration proposes that alliances maintain exclusive control over the marketing of approved health plans. Agents are to be replaced by printed report cards on participating plans, interactive media, and advertising.

We do not believe any "1-800" number, gray government manual, interactive technology, or any other new system can adequately replace the hands-on, personalized advice and independent advocacy that agents provide to their clients. Although the Clinton Administration wants to believe insurance agents are part of the problem, we believe, health insurance agents are actually an important part of the health care reform solution. Perhaps the Administration is not aware that:

- Agents help more than 200 million Americans gain access to health care security.
- Agents are the consumers' advocate fighting bureaucracy -- public or private -- to get consumers the benefits they deserve.
- Agents are the "employee benefits department" for millions of small employers who cannot afford a full-time human resources department.
- Agents are cost-effective, compensated only when clients consider them valuable. Agents can be fired at any time the client is dissatisfied with their service.

Consumers are aware of this reality. Consider the evidence from my own state of California. Under legislation authored by Assemblyman Burt Margolin, California's health alliance began operations on July 1 of this year. That health alliance, known as the Health Insurance Plan of California (HIPC) is open to small businesses of from five to 50 employees. Already over 1,000

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California firms have signed up for the state's new health alliance. Over 72 percent have specifically chosen to enroll through agents.

The state agency overseeing California's HIPC recognized that agents add value to products we sell and service. Small employers are voting with their pocketbook that they agree. These business owners recognize that professional agents do far more than merely sell health insurance. Rather, we spend a majority of our time servicing our clients. Consumers will always have questions and, regardless of the best intentions, they will always face problems. Agents are who consumers turn to -- and want to turn to -- for answers and solutions. Agents who meet the ongoing needs of their clients succeed. Those who don't get fired. It is that simple.

Still, NAHU does not insist that all health plans be required to distribute and service their products through agents and brokers. We simply believe that health plans should not be prevented from employing agents and brokers when they choose to do so. Whether to use "W-2" or "1099" employees should be a business decision left to the carrier -- or health alliance -- and not subject to micro-management through legislation.

In sum, both the Administration's and NAHU's plans seek to provide universal access to affordable health care and to reduce the increase in overall spending on health care. Both reject an exclusively government run system by relying on private carriers and providers. The most significant area of disagreement, however, lies in the respective degree of government intervention into the marketplace.

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HEALTH ALLIANCES

The Administration can easily accomplish its objectives without creating exclusive purchasing cartels. Yet, they have articulated an inflexible position on this issue, so allow me to explain why they will not work as the Administration has proposed and what can be done to improve them -- without creating new government bureaucracies and without the government making the leap from regulator to competitor in the marketplace.

Members from both parties are anxious to experiment with purchasing pools. If health alliances are to be part of the ultimate reform package, NAHU urges Congress to recognize that they are experimental and treat them accordingly. We strongly urge that any and all health alliances be privately organized and voluntary in nature and be required to compete on a level playing field with other health alliances and with private carriers operating outside the alliance structure.

This is the approach taken by eight of the nine states that have already passed legislation establishing health alliances. It is how the nation's first operational health alliance, the Health Insurance Plan of California, operates. And it has several advantages over the exclusive health alliance model.

When health alliances compete on a level playing field with private carriers they have a strong incentive to provide top quality customer service. If they fail to do so, they lose business. Exclusive health alliances have no such incentive. This reality has led the Jackson Hole group to recognize that they were wrong in calling for exclusive purchasing cooperatives.

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When health alliances compete on a level playing field with private carriers they tend to improve the offerings of private carriers and are forced to improve themselves. Competition between the California health alliance and the private sector has improved both the state plan and private carriers.

When health alliances compete on a level playing field with private carriers they have the chance to prove themselves -- without endangering consumers. Health alliances are experimental. They may thrive or they may fail. If they thrive by better meeting the needs of consumers, consumers win. If they fail, it means that entrepreneurs are better able to meet the needs of consumers, and consumers still win. Voluntary alliances are the only sure way to guarantee that consumers come out ahead regardless of the results of the experiment.

Proponents of exclusive health alliances will argue it is the only way to eliminate adverse risk selection. However, this argument fails to recognize that health alliances are to be created within the context of other far reaching reforms, most notably the requirement that all health plans be made available to all consumers regardless of their risk factors. If health alliances and private carriers offer products containing the same essential benefits and on a guaranteed issue basis, there is no reason why the health alliance should receive more than its share of high risk individuals.

The necessary mechanism for adjusting any remaining risk between health plans operating in a system of multiple voluntary private alliances is identical to that envisioned under exclusive health

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alliances. There is no need to duplicate this expertise from alliance to alliance; rather, state departments of insurance -- somewhat ignored under the Clinton plan -- can serve in this role.

There is also no reason why meaningful, comprehensive health care reform cannot be achieved in this Congress. The challenge is great, but so is the need for action. NAHU has offered a recipe for change that has numerous elements in common with the Administration. We stand ready to work with you and the White House to work through our differences.

Thank you for your attention and I will be pleased to respond to your questions.

END

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REAL CHOICE

Universal Access

to

Affordable Health Care Coverage

The National Association of Health Underwriters'

Plan for Comprehensive Health Care Reform



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HEALTH CARE REFORM CONSUMER BILL OF RIGHTS

National Association of Health Underwriters

The National Association of Health Underwriters is committed to comprehensive reform that builds upon the strengths of the American health care system to provide all consumers with accessible, affordable care.

NAHU believes consumers have certain rights regarding medical care, which any reform program should protect. These rights are:

- (1) The right to guaranteed, uninterrupted coverage of essential medical care.
- (2) The right to affordable coverage and care based on fair and reasonable pricing practices.
- (3) The right to know the costs of proposed health care treatments and insurance coverage before they are delivered.
- (4) The right to select from among quality health care providers with whom consumers can build long-term relationships.
- (5) The right to treatment through proven medical practices based upon scientific outcome research.
- (6) The right to select health care coverage from among qualified insurers, properly regulated to assure financial security and prudent management.
- (7) The right to seek expanded coverage and care in the open marketplace.
- (8) The right to tax deductibility of all costs of an essential medical package.
- (9) The right to the innovations and quality of a competitive, privately based system of health care and coverage.
- (10) The right to seek professional consumer counselors and advisors in selecting coverage and obtaining benefits.

Implementing Goals

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NAHU believes these rights can best be delivered in a cost-effective manner to American consumers only through a restructuring of the nation's health care system. The new plan should build on the strengths of our current system while expanding access and constraining costs.

This new structure would provide universal coverage of all Americans through a fair and stable marketplace in which consumers have a variety of choices among affordable health plans.

It is this emphasis on choice that differentiates NAHU's recommendations from many other reform proposals. A single payer system would give government complete control over the health care of American citizens. Even Managed Competition as originally proposed by the Jackson Hole Group, while permitting consumers to choose among competing health care providers, restricts consumers to the care and services of a single purchasing pool.

NAHU believes a better means of achieving the common goal of universal and affordable coverage is through a system of competing providers *and purchasers* of health care coverage in a marketplace characterized by a level playing field. The decisions of well-informed consumers should police the marketplace and determine the best possible health care choices, not decrees of public or private bureaucracies.

To that end NAHU proposes a plan of REAL CHOICE. REAL CHOICE is a proposal that eliminates abuses; brings economic incentives to consumer medical care purchasing decisions; establishes mechanisms for appropriate governmental regulation; promotes the elimination of administrative inefficiencies; and preserves choice for each American in meeting personal health care needs.

Components of the REAL CHOICE Plan

NAHU's REAL CHOICE plan envisions:

Multiple Voluntary Purchasing Pools

Health care coverage is available to employers and individuals through traditional health insurance carriers (including health maintenance organizations) and multiple local health alliances. Unlike traditional plans such as Multiple Employee Trusts which usually offer enrollees coverage through only one or at most two providers, each local health alliance negotiates with and selects health plans that compete for membership among the alliance's enrollees.

REAL CHOICE seeks to create a system that preserves consumer options and promotes marketplace fairness. Therefore, participation in local health alliances by carriers and consumers is voluntary. NAHU opposes the creation of government sponsored or operated local health alliances, but where they exist, they should compete on a level playing field with private sector

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health care plans. Guaranteed access, renewability, limits on pre-existing condition exclusions and other carrier reforms apply equally to private sector carriers and local health alliances.

Local health alliances are an experimental form of health care delivery, untested anywhere in the world. Several states are now in the process of establishing different versions of purchasing pools. The National Health Board (NHB, described more fully below) will monitor these state experiments to measure their effectiveness at reducing costs and increasing access in comparison to efforts by private carriers. After no more than three years of study, and annually thereafter, the NHB will publish its findings.

National Health Board

A National Health Board oversees the health care system. Recognizing that decisions of consumers in the marketplace can most effectively determine the best possible health care choices, REAL CHOICE limits the NHB to those tasks that require national monitoring. The NHB shall:

1. Establish an essential benefits package for purposes of determining tax deductibility;
2. Publish outcome studies and establish practice parameters (see Cost Containment below);
3. Establish minimum financial and operational guidelines to assure consumers of health care coverage provider solvency and capability;
4. Recommend enabling legislation to level the playing field among providers, payers, and purchasers of health care. In cooperation with the National Association of Insurance Commissioners, the NHB also helps develop common definitions for key policy terms and requirements such as "reasonable and customary," "co-insurance," "stop-loss" and "out-of-pocket maximum" to reduce consumer confusion regarding benefits.

Basic Benefits

The NHB will develop a list of core medical services which, at a minimum, must be covered by every health care program. The NHB also establishes an essential benefits package or packages which cover only core services and with cost not to exceed the maximum tax subsidy. An essential benefits package must be offered by all local health alliances and carriers. Carriers and local health alliances may offer any additional plan design. No local health alliance or carrier may be required by state legislatures to provide benefits not specifically required by the NHB.

The NHB also establishes maximum co-payment schedules for subsidized consumers (those at or below 200% of the poverty level). The need for Medicaid will be systematically eliminated. Consumers are free to choose higher co-payment levels with access to tax-free Medical Savings Accounts to assist in financing their additional expenses.

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Tax Subsidy

People earning less than 200% of the federal poverty level will receive an advanceable refundable health insurance tax credit equal to the cost of an essential benefits package. Above 200% of the federal poverty level, the credit is phased out. The credit is refundable meaning that even those people who owe no taxes will still receive the health insurance tax subsidy.

Tax Deductibility

The entire cost of health insurance is tax deductible for any business, whether corporation, partnership or sole proprietorship. Any premium paid by an employer in excess of an essential benefits package is taxable to the employee. Premiums paid by an individual for any essential benefits package are tax deductible. Through their tax free status, Medical Savings Accounts encourage consumers to save for medical expenses and buy cost-effective care.

Guaranteed Access, Renewability, & Portability

No group or individual may be denied coverage by any carrier or local health alliance based on occupation or health status. Rate surcharges based on risk factors will be limited. No exclusions for pre-existing conditions are permitted when an insured maintains continuous coverage and has satisfied a one-time, six-month waiting period. All coverage is guaranteed renewable and portable. A method permitting all carriers to reinsure their risks will be established.

Consumer Advocates

Today, consumers have access to independent insurance agents who provide information on carriers and benefits, handle grievances, and answer consumer questions. Moreover, consumers can select, change or fire their own agents at any time. REAL CHOICE recognizes that no "800 number" can replace the hands-on, personalized advice and independent advocacy that agents provide. Some proposals, such as the Managed Competition model, remove this consumer benefit by limiting individuals to the services of a single local health alliance. REAL CHOICE keeps this power in the hands of consumers by requiring that those who sell or give advice concerning the purchase of health care coverage be licensed and regulated professionals.

Cost Containment

REAL CHOICE recognizes that the only long-term means of restraining health insurance premiums is to constrain health care costs. Therefore, REAL CHOICE calls for the NHB to:

1. Develop standard medical practice guidelines and establish outcome studies as tools for cost-effective treatment and for determining essential levels of care. These outcome studies are published on an annual basis to educate consumers regarding the quality of care available from providers.

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2. Require the disclosure of the cost of services to patients in advance of treatment to permit them to compare the cost of medical services to be purchased.
3. Establish limits on referrals by providers to facilities in which they have an ownership interest.
4. Establish methods of uniform and paperless claims transactions to be used by all payers of care.
5. Create a standard, consumer-friendly application for coverage forms to be used by all carriers and local health alliances.
6. Require mediation or arbitration prior to trial of all medical malpractice suits and limit awards in excess of actual damages to the plaintiff.

Health Security Card

Every American will receive a Health Security Card from their payer which will facilitate immediate provider payment. Standards for electronic claims processing will be developed. It will also make health history immediately available to health care providers through an electronic data interchange although privacy considerations will be protected.

Cost Disclosure

To help consumers make purchasing decisions, the NHB will establish Comparison Schedules for all medical services. Doctors and hospitals will be required to disclose to the NHB their charge for each service. The NHB will publish the charges and the percentage difference of those charges from the Comparison Schedules. The NHB will make those charges, percentages, and provider outcome results readily available to all consumers. Carriers and local health alliances will be required to publish the percentages of the Comparison Schedule their policies reimburse Fee-For-Service providers for each service covered. By making comparisons, consumers will be able to help control their out-of-pocket expenses. The resulting marketplace pressure will act to limit prices.

Requirements To Purchase Coverage

REAL CHOICE requires all consumers to participate in the health care coverage system. Employers are required to offer coverage and maintain payroll deductions. Employees declining their employer's offer must purchase qualifying individual coverage through a local health alliance or a private carrier. Low income and indigent Americans will receive refundable tax credits on an income-graduated scale to subsidize their payments or payments made on their behalf.

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REAL CHOICE: Affordable, Accessible

The REAL CHOICE strategy preserves the benefits of a free market system while advancing access to affordable health care. It recognizes that the cost of health care is ultimately paid by consumers. It is sensitive to the ability of consumers, both individually and in the aggregate, to pay for that care. It also permits the orderly development of workable changes to minimize disruption and maximize consumer choices.

REAL CHOICE will result in comprehensive reform making health care coverage affordable and accessible to everyone without destroying a system that currently works extremely well for the vast majority of consumers.

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Mr. WAXMAN. Thank you very much for your testimony. You both testified that exclusive regional Health Alliances represent an untested approach to insurance market reform. Certainly none of us can dispute that. On the other hand, you both recommended competition among voluntary alliances as a preferred approach.

Now, I am sure you heard our previous witnesses predict that such a model would likely result in a continuation of competition based on favorable risk selection. What evidence do you have that alliance competition would control the growth in health premiums for all, and how can we avoid the creation of small pools based on cherry-picking healthy people that prevent the cost of health care from being spread broadly and fairly in a community?

Mr. KATZ. Well, in California, we have a very short period of experience with the only full functioning Statewide voluntary Health Alliance. It began taking its first enrollees with effective dates of July 1st. There was some concern that they would be receiving higher risks than would occur in the private marketplace.

The experience thus far seems to indicate, and it is very premature to make any final conclusion, but seems to indicate based on the spread of ages that are enrolling in the California, the health insurance plan of California, or HIPC, that they are not being adversely selected against.

We would also argue that when you have a level playing field, when all carriers, government-sponsored Health Alliances, private Health Alliances, private carriers, have to guarantee issue their coverage of all their health plans to all applicants, they can't exclude preexisting conditions, they have to renew their benefits.

There are limits placed on the ability to raise rates because a consumer dared to use the insurance they purchased. When those reforms are in place and applied evenly to all carriers and Health Alliances, the likelihood of cherry picking is virtually eliminated. If it remains a problem, then we would support the establishment of risk adjustment mechanisms that applies across the entire marketplace. And one does not need an exclusive Health Alliance for a risk adjustment mechanism.

Ms. NELSON. I would say exactly the same thing if I could say it.

Mr. WAXMAN. I think we can all agree that our Nation needs to take effective action to stop the explosion of health care costs and the President has proposed a combination of market reforms backed up by a limit on premium increases. Exclusive regional alliances are an essential part of these market and regulatory reforms.

You have testified in opposition both to the President's reliance on exclusive regional buying groups and on his proposal to cap premium increases. You argue that consumers stand the most to lose under caps or global budgets. Yet we have had consumer witnesses and corporate witnesses appear before us demanding premium caps as a protection against the double-digit health cost increases that they have had to absorb.

What concrete assurances can you give to small and large businesses and to individual consumers that under your approach they will be protected from the relentless upward spiral in health care costs?

Mr. KATZ. There are a number of cost containment provisions built into the Clinton administration's proposal, as well as proposals put forth by Congress and in the National Association of Health Underwriters real choice proposal that deal with the underlying engine driving up health insurance premiums, and that is the inflation in medical care costs. That is where we really need to focus our attentions.

Price controls in the past have not worked that well. We do not believe the premium caps are the first line defense in achieving the kind of cost savings that we feel will take place in a better regulated market. I will note that in California where the private carriers are obliged to guarantee issue products, there are limits on exclusion of preexisting conditions, and similar carrier reforms that are included in the Clinton proposal, prices did come down.

In the private marketplace and the Health Alliances, one of the more competitive plans around, but frankly it is not the most competitive plan in the marketplace and they will admit that as well. The market seems to do a good job when there is true competition in driving down costs.

Mr. WAXMAN. So what would be our assurances for cost controls?

Mr. KATZ. Assurances would be the studies such as Mr. Wyden was talking about earlier, studies to determine what are the most cost-effective treatments for various diagnoses and establishing practice parameters so that doctors in Los Angeles are as aware of doctors in Charlotte, which treatment is most cost-effective. Two treatments may both cure the patient, but what is crucial is what is most cost-effective. We need to eliminate the gridlock of paperwork that exists by establishing standardized claim forms.

There is a whole series of cost containment provisions included in my written testimony, many if not most of which are also included in the Clinton administration plan that we believe will have a substantial effect on driving down the cost of medical care.

Mr. WAXMAN. Thank you.

Ms. NELSON. Mr. Chairman, if my voice will allow, I will tell you that the State of Maine has passed all the insurance reforms that we are looking at: Guarantee issue, portability. We are looking at, right now, claim forms. We will be using universal claim forms as of December. We are starting to see those rates level off.

We are starting to see the competition, the fact that we are now offering our consumers the products they have been looking at without the underwriting regulations we have had to go through all these years, we are starting to see the change happen in rates in Maine as well.

Mr. WAXMAN. Thank you very much.

Mrs. Collins.

Mrs. COLLINS. It is apparent that the President's bill, if enacted, will result in the creation of a substantial number of new jobs, particularly at the Health Alliance level. Yet it seems to me that the agents are probably concerned that the reformed plan will affect them in a distinctly different manner, and one such manner may be that the agents might no longer be able to collect commissions on the sale of health insurance if the bill were enacted.

Is this an accurate statement, either of you or both of you?

Mr. KATZ. In California, the Health Alliance uses a fee-based system as opposed to a commission system, and California agents are very accepting of new models for providing compensation. It is not—I am not sure if your question is, are we concerned about the commission system per se or about some compensation. Obviously, we add value to the system. We hope to be compensated for that value.

Mrs. COLLINS. You agree with that.

Ms. NELSON. Yes, I would. I think the other thing is, I have been asked many times, "When this happens, will I in fact be out of business?" If I am reading the Clinton administration proposal correctly, yes, business as I know it today, I will be out of business.

My secretary, every time she types something regarding health care, she walks in and says, now am I going to be employed longer. I think that is true and I don't think Congress is going to design a program just so I am still in business 5 years from today. I would like to think that Congress will design a program that allow my clients and my consumers the choice of having my expertise for them.

Mr. KATZ. Madam Chairwoman, may I add that health underwriters are not advocating that all health plans be required to use agents. There are health plans out there that sell direct already to consumers. We just believe that the choice that carriers have to use independent advocates, independent agents, or to distribute and service their products through full-time employees should be left to the marketplace and not to micromanagement.

Mrs. COLLINS. Then I think the next question is, if the President's bill were enacted, to what extent would you expect your members to seek employment in the Health Alliance or to participate in the sales of, say, long-term care or supplemental or other types of insurance?

Mr. KATZ. Well, it has been said that, for insurance agents, the President's plan is both bad news and good news. The bad news is we would be out of a job. The good news is our health insurance would be free.

Some agents I believe would go work for Health Alliances, but the kind of men and women who are attracted to the insurance profession tend to be small entrepreneurs. Most agencies are relatively small, a handful of employees, if any employees. We are not the kind of people who are looking towards becoming Federal bureaucrats. I was a Federal bureaucrat.

I was chief of staff to the Lieutenant Governor in California and an attorney with the Securities and Exchange Commission. I don't consider bureaucracies to be evil and bureaucrats to be a four letter word, but I chose to become an insurance agent because I believe the products we sell and the services we provide have real value.

As far as other lines of insurance products, to a certain extent, skills are transferable. But to do a good job as an insurance agent requires a tremendous amount of technical expertise, whether you are selling life insurance products, long-term care products, or health insurance, major medical products.

What this proposal would do is tell insurance agents who have spent maybe their entire professional careers, people who have had a more secure job environment than perhaps I did, tell them that

the expertise they have developed over a lifetime of work is now unnecessary and it is time for them to go back to school and learn a new profession, even though it would be operating under the same license.

Mrs. COLLINS. In your written statement, Ms. Nelson, you indicated that there will still be a need to troubleshoot between the insured and the provider. Assuming the President's plan is enacted, to what extent will your members seek to administer claims for the Health Alliances?

Ms. NELSON. Madam Chairwoman, I think that goes back to your original question: Would I go to work for the Health Alliance? I think that is the major question right there. As far as working with clients, if it is a voluntary situation where I am still going to be talking with my clients and my consumers, I would certainly be there to help them. I think one of the previous panelists talked about the situation about how these people are going to have problems with claims and physicians handled.

Right now, all they do is call my office, and I do all of that work for them or one of my staff does. So from that point of view, I guess I would certainly be helping them if I were still in my position. If I went to work for the alliance, I don't know if I would still have the opportunity—I am not sure the alliance would allow me to go out to my clients, I am not sure, as an employee.

Mrs. COLLINS. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mrs. Collins.

Mr. Stearns.

Mr. STEARNS. Thank you, Mr. Chairman.

Congress is concerned about health insurance administrative costs. In that regard, I am curious about agent compensation in the small group health insurance market. Specifically what is a typical commission for an agent in this area?

Ms. NELSON. As I have checked my records, Mr. Stearns, I think that my commissions probably range anywhere from 1 percent to 10 percent. It depends on the size of the group, the type of product that they have purchased, whether they are fully insured or self-insured, so I think it could go anywhere in there.

Mr. STEARNS. Mr. Katz.

Mr. KATZ. I would agree with that with 5 to 7 percent perhaps being the most common in the very smallest groups, less than 50 employees.

Mr. STEARNS. Kindly tell us what you do for your clients to justify the commission you just mentioned, and what things do you do that a Health Alliance or purchasing cooperative could not?

Ms. NELSON. I think I would like to start that one, if my voice will stay with me.

I think the reality is that I will go—I will go to their place of business. I will go to their home. I will go to their place of business if it is a manufacturing company and we are talking about enrolling people. I have been there at 6 o'clock in the morning as well as I have been there at 11 o'clock at night to hold an employee meeting to explain what type of benefits they have.

I don't see anyone from the Health Alliance going out there, and I try to think of the Health Alliance as a government organization and I am trying to remember the last time I talked with a Medi-

care person who said that someone from Medicare came and helped them to fill out a claims form or the last time someone from the IRS came to my office and helped me fill out my tax forms.

From my point of view, what we give them is personalized service. Especially in a small company, we get to know all the employees. Many times the employee will say, I don't handle, this my spouse does, and many times the spouse will call the office.

Mr. STEARNS. Mr. Katz.

Mr. KATZ. I think that is probably the most crucial distinction I would add, that it is important to remember that health insurance agents just aren't selling all the time. Most of our time is spent in servicing the products and advising our clients.

Small employers don't have the luxury of an Employee Benefits Department. What they are able to do is use an agent who not only helps them with their major medical policies but may help them with a variety of other employee benefits, explain to them how COBRA and ERISA and all these acronyms that they have to deal with work and can be quite challenging to a small employer whose primary concern is succeeding as an enterprise and making the monthly payroll.

Mr. STEARNS. Some people might think as an agent you merely opt for the highest priced plan in order to receive a higher commission. I would like you to respond to that and also the other question: Will the Clinton plan put you out of business by virtue of their exclusive or mandatory Health Alliances?

Mr. KATZ. As far as the second part of your question, yes, the Clinton proposal, as I mentioned, will put health insurance agents out of business. As far as our desire to sell only the highest priced plan, that is a recipe to wind up in another profession. It is a very competitive marketplace.

In California we estimate that there are probably 30 to 35,000 agents who earn a significant portion of their income through the sale and service of major medical policies. If an agent goes to a client and sells them the highest priced plan, I guarantee you that that client at the next Kiwanis meeting or the next Little League game at the church social is going to bump into a health insurance agent who is going to be able to provide them with information about ways to save money. Insurance agents succeed by making sure that they are putting their clients into the plan that best fits their needs and their budget.

Mr. STEARNS. Ms. Nelson.

Ms. NELSON. I don't know if I would have——

Mr. STEARNS. Anything you would like to add to that?

Ms. NELSON. I don't know that I would have anything to add to that other than to strongly tell you that if I am walking in there and I am only selling the highest product because I think I am going to get paid the most money, I am going to lose that client very, very soon. And I am happy to say in my particular business, my retention is about 92 percent, which means from the time I write a client as long as they stay with me, 92 percent of my clients have been with me since the first day we wrote a case.

And I have done that because I have tried to find them the most competitive and the product that fits their employees the best.

Mr. STEARNS. Perhaps you heard the previous panel. When I asked them this question, they said the agent should look—see the handwriting on the wall and that I think their argument was that there will be a decrease in the number, whereas Mr. Katz has indicated he will go out of business. So there seems to be a little difference of opinion between you folks and the other panel.

Ms. NELSON. I don't think so because I think there were two questions. I think one was if the Clinton proposal goes the way it is right now, as closed HIPC's or closed Health Alliances. I think we are talking in a voluntary market, will our role change? I think absolutely. But I think if you are saying will an insurance agent still be able to purchase and to sell insurance under the Clinton plan, we don't.

Mr. KATZ. I would just add there is a difference between the Florida Health Alliance mechanism and model and the Clinton model.

Mr. STEARNS. Voluntary?

Mr. KATZ. Right. And by the way, health insurance agents have been advocates for health care reform for years. We are the ones who helped put that writing on the wall.

Mr. STEARNS. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Stearns.

Mr. McMillan.

Mr. MCMILLAN. Thank you, Mr. Chairman.

You know, reading this thing over and over again and talking with different groups, I am convinced the way it is structured it will not only eliminate insurance agents, it will eliminate insurance underwriters. In the end, the Government will be the banker of last resort.

I think there is a better way to do it, and I think both of you have outlined a lot of them. I know, for example, one independent insurance agency that operates with about 5 people that manages group plans in excess of 37,000 students at Duke University, and the University of North Carolina, very efficiently. The administrative costs for running that thing are very inexpensive. Nobody came in and required the company to do this.

I think your industry has the capacity to respond in a real creative way and you would be marketing not just individual policies, you would be marketing participation in competitive alliances to provide what people want for the maximum amount of choice.

I happen to think that there are some good alternatives to the Clinton plan which the President is aware of and ultimately may well become a part of a final package. The Republican alternative has excellent provisions with respect to malpractice reform, product liability reform, antitrust waiver to encourage constructive combinations and joint ventures, and administrative reforms, all of which you all have touched on.

I don't think the Republican plan goes quite far enough, so I have been working with the idea of instead of mandating to institutions and groups, you mandate essentially to the individual, but you provide the means of paying for it on a means-tested basis through a certificate system that enables that individual to go anywhere they choose and purchase with the Federal subsidy related to their income whatever among a number of competing acceptable

plans may be out there which I think would elicit a competitive response from the—from providers all across the country whether they be insurers or whether they be hospitals or groups of doctors or what have you.

I don't think anybody loses in that proposition other than those who think that a private sector response won't work, that it has to be essentially price controlled and managed. That is always a last resort if the other doesn't work, but I happen to think that a market-based solution would work extremely well and is one that we should look at.

I don't have a lot of specific questions, but suppose there were a certificate system as I have described and a person walked in to what you might envision your industry doing in response to the right kinds of reforms, what would you do if a Medicaid qualified individual, say, at 100 percent level of poverty with a Federal certificate that said that the government would fund 100 percent of the actuarial cost of a base extended package for a person at the poverty level, would they get serviced by your kind of organization?

Mr. KATZ. Definitely. That is what our members do for a living. We would sit down with that individual. We would examine what their needs are, for instance their family medical histories, their goals as far as what they want from their health plans, their willingness to accept a restriction on doctors in order, perhaps, to obtain additional benefits, or their desire to maintain complete freedom of choice as a possibility. We would sit down and we would help that person.

The program you have outlined, Mr. McMillan, is very similar to that put forward by the National Association of Health Underwriters in our real choice proposal. As I mentioned in my testimony, we are looking forward to working with you and the chairwoman and the chairman and the White House on coming up with reforms that actually work for consumers providing them the choice we believe they deserve and are asking for.

Mr. MCMILLAN. Do you think anybody that is at the lower income end of scale cooperating on a freely competitive system like that and let's say you are marketing 15 different alternatives within your own area some of which are managed care plans, some of which are underwritten, whatever the market puts out there, and let's say we effectively deal with the issue of adverse risk selection, there isn't any. If it is, it isn't going to work. I am a free market person but I know that simply will not work. There are ways to cure that.

Would you see a person either at the lower income end of the scale or a person with less sophistication in dealing with their own medical care needs would come out short under such a system?

Mr. KATZ. I don't believe so. One of the things I found in the insurance industry among the agent community to be most proud of is that, for years, it has been a profession with easy access to women and minorities across—in my experience, across California.

There are insurance agents in virtually every community. I do not think that low income necessarily means in any way, shape, or form, that that person can't with the advice of a professional health insurance agent make the decisions, the buying decisions as to what type of plan and what health plan best fits their particular

family's needs. And I think they will find resources available to them through professional agents wherever they live.

Mr. WAXMAN. Thank you, Mr. McMillan.

I want to thank both of you for your testimony today, and you have raised some very important points for us to think about and we want to look forward to working with you further. Thank you.

Mr. KATZ. Thank you.

Ms. NELSON. Thank you.

Mr. WAXMAN. That concludes our hearing today. We stand adjourned.

[Whereupon, at 1:04 p.m., the subcommittees adjourned, to reconvene at the call of the Chair.]

HEALTH CARE REFORM Insurance Market Issues

TUESDAY, NOVEMBER 9, 1993

HOUSE OF REPRESENTATIVES, COMMITTEE ON ENERGY
AND COMMERCE, SUBCOMMITTEE ON HEALTH AND THE
ENVIRONMENT, AND THE SUBCOMMITTEE ON COM-
MERCE, CONSUMER PROTECTION, AND COMPETITIVE-
NESS,

Washington, DC.

The subcommittees met, pursuant to notice, at 2:30 p.m., in room 2123, Rayburn House Office Building, Hon. Cardiss Collins, chairwoman, Subcommittee on Commerce, Consumer Protection, and Competitiveness, and Hon. Henry A. Waxman, chairman, Subcommittee on Health and the Environment, presiding.

Mrs. COLLINS. Good afternoon. I would like to welcome everyone to today's joint hearing on the Long-Term Care Insurance and Supplemental Insurance Issues within the President's Health Care Reform Bill.

Long-term Care Insurance policies, as well as the practice surrounding their marketing and sale, are currently fraught with pitfalls. The Commerce, Consumer Protection and Competitiveness Subcommittee held hearings in the last Congress which exposed many of the problems and questionable practices associated with this product, including: The high rates at which these policies lapsed, often with a total loss of all equity that had been accumulated over years of paying premiums; the techniques that are used by some insurers to avoid paying claims; the diminishing value of a policy over time, if it does not include inflation protection; the high-pressure sales tactics and, in some cases, exorbitant agent commissions, that often lead to inappropriate purchases and churning from one policy to another; and the extraordinarily high premium increases that often accompany renewals of these policies.

There are certainly many well-principled, scrupulous insurers and agents involved in long-term care insurance. However, there are others who are not. In fact, the problems are so prevalent, that some critics consider this product to be unworthy of purchase. At a minimum, there is an urgent need for strong Federal Regulation affecting a broad range of policy features, marketing materials and tactics and sales techniques.

Having introduced legislation both in the 103rd Congress and the 102nd to establish Federal standards for long-term care insurance, I am particularly pleased that President Clinton has recognized the depth of problems in this area and has included provisions in the Health Security Act that are along the lines of my bill. Consumers

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deserve a safe market, where they know that they can purchase genuine benefits at a fair price without any harmful surprises.

It is encouraging that these thoughts are shared by some of the industry too, who do not want consumers scared away from the product due to the hazards presented by the bad actors in the business.

As to the second subject of today's hearing, although the benefits package in the President's proposal is quite comprehensive, the proposals permit insurers to offer supplemental insurance. There are two permissible types of policies: One which would provide benefits in excess of the basic benefit package, and the other which would pay the cost-sharing and other expenses for which the enrollees would otherwise be responsible.

Our experience with Supplemental Insurance for Medicare recipients, known as the Medigap policies, has taught us that some limited Federal regulations can aid consumers. Regulations are necessary so that consumers are not being sold insurance or benefits to which they are already entitled. Regulations can also standardize the terms of the policies, so the consumer is in a better position to compare the policies and costs. While it is important to provide an opportunity for the purchase of supplemental insurance, we must also avoid the sale of policies which are virtually worthless.

I want to thank our witnesses today for appearing before us. I look forward to hearing your testimony.

Mr. Waxman is Co-Chair of this particular hearing today, as chairman of the Subcommittee on Health and the Environment. Mr. Waxman.

Mr. WAXMAN. Thank you very much, Madam Chairwoman. The purpose of the hearing today is to consider the provisions of the President's Health Reform Plan that deal with private, long-term care insurance policies and private policies that supplement the guaranteed benefit package.

It is obvious that we do not meet the needs of elderly Americans and people with disabilities. The fact is most Americans are currently at a substantial financial risk for nursing home and home-based services. Nursing home care is expensive, at an average cost of \$30,000 a year. It can quickly deplete the resources of most elderly individuals.

While the Medicaid program provides about 45 percent of payments for nursing home care, it does so only after individuals have impoverished themselves. Compounding this enormous problem is the fact that payment policies under Medicaid have traditionally forced the disabled and the elderly into nursing homes for their care, even though many people can and prefer to be treated at home.

The President's health reform plan takes significant steps to address these long-standing problems. His bill would include a new Federal State program of home and community-based services that would be open to all, regardless of their age or income. I know we are going to have a hearing on that at a later time.

Today's hearing focuses on another aspect of the President's plan—the need to eliminate abusive marketing and sales practices in the private, long-term care insurance market. All Americans who seek to protect themselves against the high cost of long-term

care are at risk for this unacceptable behavior. The President's bill establishes Federal minimum standards for long-term care insurance products, enforced through State regulatory programs approved by the Secretary of HHS.

We have asked the witnesses today to comment on the need for these proposed standards and how they can best be enforced. I also look forward to hearing the witnesses discuss the President's proposed standards for marketing and sale of private supplemental health policies. These are policies that cover benefits not included in the basic package, and to cover the cost-sharing required in the President's plan.

I believe there is broad agreement that private, long-term care and supplemental policies should continue to be available to those Americans who wish to purchase them. I hope there is also broad support for the need for effective consumer protections in these markets.

I look forward to hearing from our witnesses. Thank you for recognizing me.

Mrs. COLLINS. Thank you. Mr. Stearns.

Mr. STEARNS. Thank you, Madam Chairwoman. Today's hearing focuses on long-term care, both nursing home care and home and community-based services.

In my State of Florida, over 72 percent of all Medicaid payments for the aged go to nursing home care. Over 67 percent of the total country's Medicaid payments for the aged go to nursing homes, with 8 percent going to home care. The cost is rising.

With the bulk of State and Federal Medicaid payments going to long-term care services, we must focus on these rapidly rising costs as we seek to enact health care reform. The President's health care bill seeks to provide \$65 billion over 5 years, to provide new home and community-based services for the disabled, money which comes from cutting Medicaid and Medicare by billions. As we seek ways to help Americans, we must make sure that our cost estimates are sound and that our sources of revenue are reliable. We would be doing Americans an injustice to create unrealizable expectations, to make promises that neither Federal nor State tax dollars can fulfill.

With these rapidly rising costs, there is a desperate need to search the private sector for incentives to help shift some portion of this burden from the taxpayer to the private insurance market. In addition, we must wring out those things which unduly contributed to skyrocketing costs. Fraud and abuse must be eliminated, tough choices must be made regarding medical expenses for the terminally ill.

On Face the Nation this past Sunday, President Clinton, himself, encouraged Americans to consider adopting living wills. Incentives need to be developed for families to take care of their own, through their own means and through the purchase of affordable long-term care insurance. The tax clarification of the deductibility of long-term care insurance should be encouraged. Individuals should take steps on their own.

In addition to looking for private market solutions, we need to ensure that consumers are getting the protection that they pay for. There have been many instances of consumer confusion, as basic

definitions and policy terms are not standardized. No standard method exists for determining when an individual qualifies for long-term care. Uniform standards which protect the consumer, while encouraging the availability of affordable long-term care insurance would be a positive step.

Many Americans mistakenly think that Medicare will cover their long-term health care needs. Educating the consumer on the need to purchase insurance and how to make a knowledgeable decision on which policy meets their needs is a must.

The President's bill provides many positives: Tax clarification for long-term care insurance, uniform standards to protect the consumer, and consumer education. However, it creates unrealizable expectations in the area of home and community-based services. In our zeal to help Americans shoulder this increasing long-term care burden, we must insure that there are sufficient Federal and State revenues to cover the contemplated long-term care services before such promises are made to a broad population of disabled.

We must clear up the existing confusion and be able to answer questions such as this: How would the Medicaid and Medicare program cuts that are to pay for these new benefits be obtained? How would States hold program expenditures to their capped allotments? What would happen to disabled individuals who meet the program's functional criteria and expect long-term care services that a State cannot afford to render?

We owe the American citizen and taxpayers the answers to these crucial questions and more.

I look forward to hearing our witnesses today. Thank you, Madam Chairwoman.

Mrs. COLLINS. Mr. Wyden.

Mr. WYDEN. Thank you, Madam Chairwoman. I want to commend you and Chairman Waxman for all of the work that you have done in this area. I, too, have legislation, much of which has been included in the President's package.

I want to say to my colleagues that, in the last session of Congress, a number of senior citizens worked with my subcommittee as undercover investigators, looking at the long-term care market and, in fact, posed as individuals who wanted to purchase policies. What we found—and we have the tapes and would be happy to show them to members of this committee—is that every single one of the agents, every one misrepresented what was in the policy package.

I think it is essential that we have consumer protections. Millions of seniors, on any given day, have these long-term care policies, and the fact is that many of these policies are essentially cash cows for the insurance companies and their agents, but end up leaving the senior citizens who purchase the policies high and dry.

The last point I would mention, Madam Chairwoman, is that the industry makes much and has, particularly in the last few months, of how things are getting better in the private, long-term care market. The General Accounting Office did a report for me at the end of this past summer, looking at the five largest insurance companies, which account for more than half of the long-term care policies sold in the country. In fact, what this report indicates is that

things are not getting any better. One of their findings was where senior citizens pay up to 70 percent of the first-year premium in commissions to the sales agents who sell the policy. The General Accounting Office found that these high fees violate standards set by the National Association of Insurance Commissioners and, in fact, violate those NAIC standards considerably.

So, I think there is much work to do here to drain the swamp, and area where we see seniors, on an ongoing basis, exploited and taken advantage of. I look forward to working with you, Madam Chairwoman, and Chairman Waxman and our colleagues on the other side to get it done.

Mrs. COLLINS. Thank you. Mr. McMillan.

Mr. MCMILLAN. Thank you, Madam Chairwoman.

In 1990, the cost of providing long-term care in this country was over \$52 billion. In fiscal year, 1991, Government outlays through Medicaid for long-term care was in excess of \$35 billion. Long-term care costs are one of the fastest growing segments of Medicaid, with nursing homes for the elderly far and away the lion's share of the expense, 58.8 percent.

Two facts about this Medicaid program stand out. Long-term care costs are consuming 42 percent of total Medicaid outlays, and are rising rapidly. There were an increasing number of individuals that are moving assets to their children, thus making the Federal Government the primary payer of long-term care through the Medicaid program.

In this year's Budget Reconciliation Bill, I added an amendment that would prohibit the transfers of these assets solely for eligibility under the Medicaid program. This is not because I do not understand that the cost of long-term care can exceed \$36,000 per year. It is because I do not think the Federal Government should be in the business of protecting people's assets with the solitary result being an increase in the size of the Federal debt, when they can bear part of the costs themselves.

I am interested to learn how insurance companies plan on marketing long-term care products and how the President's plan would introduce sound fiscal policies, combined with compassionate care for those in need of long-term care.

After reviewing the President's proposal, I am concerned that it does little to address the cost drivers in the system, and that it really does not consider that this expense can be borne by many consumers, if they have access to the right types of insurance policies. The young and middle-aged are not very likely to have an immediate need for long-term care. So, the cost to them for policies protecting against this should be relatively low. Yet, there are very few incentives for this age group to get involved in purchasing long-term care insurance, with the exception of allowing benefits paid by such a policy to be tax deductible, which is a long way off for them, and to allow deductibility of \$150 for the purchase of such a policy.

Last, I am concerned that the President's plan, once again, severely underestimates the real cost of long-term home health care. The Health Security Act has budgeted only \$65 billion, over 5 years, once it is fully phased-in for these programs. The President greatly expands the benefits and yet seems to believe that the costs

are going to decrease dramatically, since the cost to the Government for this program is already \$35 billion for only 1 year.

I look forward to the testimony of our witnesses, and hope that we can shed light on this important issue, and yield back the balance of my time.

Mrs. COLLINS. I thank the gentleman for yielding. I would note that each member knows that all opening remarks will be made a part of the record. So, I would call upon any member who now feels that he or she would like to give opening remarks.

Mr. ROWLAND. Thank you, Madam Chairwoman. I do have a statement that I wish to submit to the record. I do have some comments that I wish to make at this time. I thank you and thank Chairman Waxman as well for this hearing today which focuses on an issue which I believe to be extremely important. The issue of long-term care for the elderly, in my opinion, is really a time-bomb. Although it is already a very serious problem, it threatens to explode in a far more devastating way over the next several decades if something is not done.

The problem is the rapid growth of the aging population and the inadequate system for helping people pay for long-term care and nursing homes or through home health care. For many families, this means experiencing ruinous financial hardships, or leaving their loved ones without the care that is essential to their well-being. People are literally having to spend down their financial assets to qualify for nursing home care through Medicaid.

Even though the Federal Government will continue to do its share, I believe that, in light of the budgetary constraints caused by the large budget deficits we have, more consideration should be given to expanding the role of the private sector in the financing of long-term care.

Earlier this year I introduced H.R. 862, which allows all individuals, aged 59 or over, to withdraw funds from IRA accounts to purchase long-term care insurance without a tax penalty. In fact, I introduced this legislation in the last Congress and the Congress before that. By encouraging citizens to buy long-term care policies, this legislation would greatly aid Americans in planning for care that they may need in later years. It also encourages more private sector involvement in the financing of long-term health care expenses.

I am also aware that several of my colleagues have introduced legislation focusing on long-term care insurance initiatives as well. I look forward to working with them and the administration on this issue in the future. I believe that every effort must be made to give America's rapidly growing elderly population and opportunity to live out their lives in dignity and in peace. I yield back the balance of my time.

Mrs. COLLINS. I thank the gentleman. Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Madam Chairwoman. Just very quickly, Madam Chairwoman. I do not have any planned remarks. I commend you and Mr. Waxman for this hearing. This is obviously a very important subject. When you come from Florida to represent Florida constituents, you can certainly see that it is a most important subject. Any plan that we have that does not take long-term care into consideration is far from a complete enough plan.

I would hope though that we would put more emphasis on nursing home care. Home health care is very significant. It is certainly, generally, less expensive; but we do not want that to preempt nursing home care.

Madam Chairwoman, just the opening statements here have brought out so many questions, that Mr. Wyden and so many others have raised—so many meritorious points. Those have just been on long-term care—just a small part of this great big package that we are talking about reforming health care, and we have not even heard from the witnesses yet.

So, just the complexities of the overall plan are amazing. If we are going to have so much trouble with long-term care, can we imagine how much trouble we are going to have with the overall plan? Yet, we can do some things now. Mr. Wyden concentrated on fraud in the pricing of policies, and breakdown of the premiums—and how much goes to the seller of the policies and things of that nature. We can do a lot of things now to help people.

If you are in the elderly category, and some of us are quickly getting there, you are concerned about help now, not downstream. We do not want to withhold help for people who are in need now, mainly because we feel that we have got to have one great, big package, and it is an all or nothing type of thing. We know how complex that is. We know how much time that is going to take.

I think it is important that we try to help people now as much as possible.

Thank you, Madam Chairwoman.

Mrs. COLLINS. Thank you.

Mr. Moorhead.

Mr. MOORHEAD. Well, thank you, Madam Chairwoman.

Let me begin by thanking you for holding this hearing today on long-term care. Nursing home care can cost upwards of \$34,000 a year. In-home care, while sometimes less expensive, is not always so. A friend of mine has just been under that kind of care, and I know it cost him or his wife \$10,000 for a 2-week period.

The only thing worse than realizing that someone needs additional care because they can no longer perform the basic function of life, is realizing this and not being able to pay for it, or, worse yet, having the Federal Government make promises that it cannot keep.

Long-term care is a natural market for insurance, and it should surprise no one that the insurance industry has developed a series of products to help defray this cost. Unfortunately, the products developed by the insurance industry are new and in an evolutionary state. Some of our witnesses today will testify to wide-spread customer confusion and lack of consensus among the insurance carriers as to what constitutes long-term care; the end result of which are usually the high lapse rates among policyholders. When these flaws are coupled with those unfortunate instances where agents and carriers place their own profits before the needs of their policyholders, the end result is that policyholders find themselves without the protection they were promised.

It is not yet clear how we can best change the long-term care insurance market to accommodate both the evolutionary nature of

these products and the need to protect the consumers of this country.

I look forward to hearing the testimony today, in the hopes that we can soon begin working towards a consensus which will allow us to deal with these problems associated with this market.

Thank you, Madam Chairwoman.

Mrs. COLLINS. Mr. Pallone? Who else is down there. I cannot see. Mr. Franks? Thank you. Mr. Hastert? Mr. Paxon? Thank you. All right.

We do have a distinguished panel of witnesses testifying before us today. All of them have extensive knowledge of or are experienced in the area of long-term health care insurance or supplemental health insurance.

The first witness on today's panel, Mr. Mark Nadel, is appearing on behalf of the General Accounting Office. GAO has conducted a number of studies on both the private, long-term care market, and the supplemental insurance market. He is here today to present the findings of these various reports.

We will hear next from Ms. Nancy Bern, who is Vice President of Group Long Term Care for John Hancock Mutual Life Insurance Company. John Hancock has been selling long-term care policies for both individuals and groups for a number of years now.

Mrs. Kathelen Spencer is Executive Vice President and Deputy Counsel of AFLAC, the American Family Life Assurance Company. AFLAC has been involved with the sale of supplemental health insurance policies.

Representing the American Health Care Association is Mr. Paul R. Willging, who is the Executive Vice President of that organization. As owners and providers of nursing home care, this group has a long-standing interest in the private long-term care insurance market.

Our final witness today will be Mr. James P. Firman, who is President and Chief Executive Officer of the United Seniors Health Cooperative. His organization, representing consumer interest, has done extensive work relating to both long-term care insurance and supplemental health care policies.

I want to thank all of you for appearing before our two subcommittees today. We have already received your written testimony, which will be made a part of the formal record. So, what we are going to ask you is to please summarize your opening statements in 5 minutes. We will be using the clock, which is a part of the rules of the House of Representatives. We will be asking questions on the same basis.

We are going to begin with Mr. Nadel. Before we do, let me say very very briefly to Ms. Spencer that I got a call from someone who probably is your Member of Congress, Mr. Sanford Bishop, who told me to give you his highest regards when you got here.

Thank you. We may begin our testimony now, please. Mr. Nadel.

STATEMENTS OF MARK V. NADEL, ASSOCIATE DIRECTOR, NATIONAL AND PUBLIC HEALTH ISSUES, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE; NANCY BERN, VICE PRESIDENT, GROUP LONG-TERM CARE DIVISION, JOHN HANCOCK MUTUAL LIFE INSURANCE CO., ALSO ON BEHALF OF HEALTH INSURANCE ASSOCIATION OF AMERICA; KATHELEN V. SPENCER, SENIOR VICE PRESIDENT, AMERICAN FAMILY LIFE ASSURANCE CO. OF COLUMBUS; PAUL WILLGING, EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION; AND JAMES P. FIRMAN, PRESIDENT, UNITED SENIORS HEALTH COOPERATIVE

Mr. NADEL. Madam Chairwoman and members of the subcommittees. I am pleased to be here today to testify on the extent to which the provisions of the administration's Health Security Act, dealing with long-term care insurance and supplemental health insurance address problems that the GAO has previously identified. In general, we believe that the long-term care insurance section contains the kinds of measures that we have advocated, and I will briefly enumerate those.

First, disclosure standards. The Act contains disclosure standards that require a standard outline of coverage for each policy. Such standards help to clarify policies as well as to help protect consumers from deceptive marketing practices. Thus, the Act requires that consumers get an outline containing a description of the principal benefits offered, limitations on coverage and premiums, among other things.

Second, inflation protection. The Act addresses the increasing cost of long-term care, in part, by providing that inflation protection be offered to consumers. Without adequate protection, inflation can greatly erode the value of benefits and in fact make them inadequate to cover costs.

Nonforfeiture benefits. The Act requires regulations that establish an appropriate return on investment in premiums when a consumer allows a policy to lapse. Insurance companies we reviewed expect about half of all policies to lapse within 5 years, which entails a major financial loss for consumers. For example, based on our review, a consumer who purchased a policy at age 75 and allowed it to lapse at age 85 would lose, on average, about \$20,000.

The Act requires that long-term care policies include uniform terms, definitions and formats as established by the Secretary of HHS. The absence of uniformity has made it difficult or impossible to compare policies and to know if any provisions would preclude your getting the benefits that you expect. Some policies would use terms such as custodial care, that were not used in other policies. Common terms for facilities, such as nursing homes, were often defined differently.

A complaint to a State insurance commissioner illustrates the problem. A policyholder complained that her insurance company would not provide benefits unless she received care in a nursing home with 24-hour nursing services. The policy also required that these services be provided by a registered nurse, yet none of the nursing homes in her area could provide such services.

In general, eligibility for services has been a problem. For example, some companies provide coverage for "medically necessary services," but do not define that important term. The Health Security Act addresses the problem of vague or confusing eligibility criteria by requiring policies to specify the levels of functional or cognitive impairments necessary to receive benefits.

The Act also covers the rights of consumers to replace or upgrade their policies with more recent policies offering better protection. It also facilitates a grievance process that allows policyholders to formally contest insurance companies' decisions about their eligibility.

The Health Security Act also deals with supplemental insurance, which Chairman Waxman ask that we address as well. It defines supplemental insurance as a policy that provides coverage for things not included in the comprehensive benefit package. It specifically excludes from the definition Medicare supplement insurance, that is Medigap, long-term care insurance, hospital indemnity insurance, specific disease insurance and accident insurance, and also excludes cost-sharing policies for which there are provisions in another section of the Act. So defined, it is unclear how large a market will remain for supplemental insurance, particularly if Congress enacts legislation with universal health insurance coverage. Nonetheless, we have previously found abuses with this kind of insurance, particularly in Medigap, and these problems are analogous to problems in supplemental insurance generally.

As is now the case with Medigap, the Health Security Act prohibits the sale of any supplemental policy that duplicates the comprehensive benefit package in the Act, or Medicare coverage, which kind of duplication was a persistent problem in the sale of Medigap insurance.

However, the administration's plan does not deal with two types of abuses we have previously identified in supplemental insurance: churning and misleading sales practices. In the past, some agents have persuaded consumers of Medigap policies to replace their policies unnecessarily to get higher first-year commissions and this resulted in new waiting periods during which policyholders were not covered for pre-existing conditions. Although the Health Security Act's section on long-term care insurance deals with commission limits, there is no such restriction with regard to supplemental insurance, nor are there other provisions against misleading sales practices. Finally, the Act does not regulate specific disease and hospital indemnity insurance which provide narrow protection.

In conclusion, we find that the Act does contain the provisions for long-term care that we previously advocated. On the other hand, the Act is less comprehensive and offers less protection with regard to supplemental insurance. That concludes my statement, Madam Chairwoman.

[Testimony resumes on p. 181.]

[The prepared statement of Mr. Nadel follows:]

STATEMENT OF MARK V. NADEL

Mr. Chairman, Madam Chairwoman, and Members of the Subcommittees:

I am pleased to be here today to testify in response to your request that we discuss the extent to which provisions of the Administration's Health Security Act dealing with private long-term care insurance and supplemental health insurance address problems we have identified previously. The Administration proposal has detailed sections that would govern the content and marketing of long-term care and supplemental insurance policies. Both of these types of insurance have been subject to numerous abuses by some agents and insurance companies as GAO has reported over the last few years.¹ In general, we believe that the section of the Administration's proposal on long-term care insurance contains the kinds of consumer protection measures that we have advocated. With regard to the section on supplemental insurance, however, some problems are not addressed. Without attempting to review or assess all the sections on long term care insurance in their entirety, I will discuss the provisions that pertain to our earlier work.

BACKGROUND

Long-term care often presents a significant financial burden for many people. As a result, many consumers purchase long-term care insurance to defray the costs of care. Supplemental insurance

¹A complete listing of our past work on this subject may be found in Appendix I.

is another type of health insurance that provides limited coverage for specific diseases or services.

Health insurance is generally regulated by state governments. To help states monitor variations in policies and sales practices, the National Association of Insurance Commissioners (NAIC), a nonprofit organization of state insurance commissioners, has developed model standards. Although the NAIC standards are not mandatory, they suggest the current minimum standards that states should adopt. To varying degrees, states have adopted the NAIC standards. Insurance companies must comply with the standards in states where they have been adopted. However, we found that policies often did not meet NAIC standards.

PROPOSALS FOR LONG-TERM CARE INSURANCE POLICIES

While long-term care insurance can provide important benefits for consumers, some policies have not provided adequate consumer protection. The Administration proposal has a number of provisions that address problems with the content of policies that have been identified previously.

Disclosure Standards

The Health Security Act contains disclosure standards that require a standard outline of coverage for each long-term care insurance policy. Disclosure standards help to clarify or simplify policies, as well as help to protect consumers from unfair or deceptive marketing practices. Thus, the Act requires that there be made available to consumers an outline containing a description of the principle benefits covered, limitations on coverage, and premiums. NAIC standards also require an outline with the same features. However, most policies we reviewed in 1991 did not meet NAIC standards.²

Inflation Protection

The Health Security Act addresses the increasing cost of long-term care in part by providing that inflation protection be offered to consumers. The Act requires that the amount of the benefit be compounded annually at not less than 5 percent a year (or other rate as determined by the Secretary of Health and Human Services). This protection can only be waived in writing by the consumer. Without adequate inflation protection, inflation can erode the benefits of long-term care insurance policies and make them inadequate to cover costs.

²Long-Term Care Insurance: Risks To Consumers Should Be Reduced (GAO/HRD-92-14, December 26, 1991).

Nonforfeiture Benefits

The Health Security Act also addresses the problems associated with policyholders who allow their policies to lapse. The Act requires the Secretary to develop regulations that establish an "appropriate" return on an investment in premiums when a policy lapses (called nonforfeiture benefits). Insurance companies we reviewed expect about 20 percent of long-term care policies to lapse during the first year of ownership and about half of all policies to lapse within 5 years. This can entail a major financial loss for consumers. For example, based on our review of policies, a consumer who purchased a policy at age 75 and allowed it to lapse at age 85 would lose, on average, about \$20,000 in premiums. Until recently, few policies offered policyholders nonforfeiture benefits. Since our study of policies, NAIC approved standards in June 1993 that require nonforfeiture benefits for all policies.³ Currently, NAIC is drafting a model regulation that will specify the types of nonforfeiture benefits that should be provided.

³Long-Term Care Insurance: High Percentage of Policyholders Drop Policies (GAO/HRD-93-129, August 25, 1993).

Services and Facilities

The Health Security Act requires that long-term care policies include uniform terms, definitions, and formats, as established by the Secretary. The absence of uniformity has made it difficult or impossible to compare policies and to know which provisions could reduce the likelihood a policyholder would receive benefits.

Some policies we reviewed used terms relative to services (such as "custodial care" and "plan of care") that were not used in other policies. Further, common terms for services (such as "custodial care") and facilities (such as "nursing home") were often defined differently and could, in effect, preclude covering the intended services or eliminate the policyholder's local nursing homes from the pool of eligible facilities. In short, the limitations of certain policy provisions may be difficult to identify. Most policies we reviewed contained restrictions on what was meant by skilled, intermediate, and custodial care, as well as restrictions regarding eligible facilities. A complaint to a state commissioner illustrates the problem. A policyholder complained that her insurance company would not provide benefits unless she received care in a nursing home with 24-hour nursing services; the policy also required that these services be provided by a registered nurse. Yet none of the nursing homes in her area met these requirements. Although NAIC has disclosure standards, they do not require uniform terms and definitions.

Although the Health Security Act requires that policies providing benefits for any nursing home must provide benefits for all types of nursing homes licensed by the State, the Act falls somewhat short in its specification of services and facilities. It allows the option of providing benefits in other types of unlicensed residential facilities, but consumers may not realize the benefits available in the facility they choose unless they receive information on the specific types and number of local facilities that are covered. The importance of alternative residential facilities, such as assisted living or board and care, is increasing. Construction of new certified facilities, or the addition of beds to existing facilities, has been restricted in some states and attempts have been made to use existing facilities for people with more extensive needs. Alternative residential facilities have been developing and their importance as a source of "institutional" long-term care may increase.

Eligibility

The Health Security Act addresses the problem of vague or confusing eligibility criteria by requiring policies to specify the levels of functional or cognitive impairments necessary to receive benefits.

In policies we reviewed, eligibility criteria were often

vague, were not sufficient to assess the eligibility of people with physical or mental impairments, or had implications for restricting benefits in ways that were not obvious. Two types of criteria illustrate these problems.

- ◆ Many insurance companies use eligibility criteria that require care to be "medically necessary." But, some policies we reviewed did not define the term. For the other policies, the definition varied. Apart from problems with the definition of medically necessary, medical necessity is not a relevant criterion for policyholders who do not need medical services. Some policyholders may need only custodial or home health care because of physical or cognitive impairments.
- ◆ Some insurance companies use eligibility criteria such as "activities of daily living" (ADLs). The activities include bathing, transferring from bed or chair, dressing, toileting, and eating. In using such criteria, companies determine impairment by evaluating a consumer's ability to perform ADLs. Although ADLs are promising criteria for determining eligibility, most of the policies we reviewed that used ADLs did not describe them. As a result, the circumstances under which the company would provide benefits was unclear. Further, some people, such as those with Alzheimer's disease, require criteria other than

medical necessity or ADLs. Such people generally do not need medical services and they may not have serious ADL limitations.

NAIC standards are silent on guidelines that address the relevance of eligibility criteria for different types of impairments.

Policy Upgrading

The Health Security Act addresses the problems faced by consumers when they try to upgrade coverage of older policies. The Act provides authority for the Secretary to set the terms and conditions that insurance companies can place on policyholders' eligibility to obtain improved coverage. The terms and conditions include any restrictions on premium increases and medical underwriting.

This is an important protection because many older policies contain overly restrictive provisions that are now prohibited by NAIC, such as a prior hospitalization requirement. More than one million consumers have purchased those earlier generation policies. Today, many policyholders who bought such policies and who want to upgrade them to current standards may do so only with significantly higher premiums. In addition, the policyholders must meet the same requirements as new purchasers, such as medical criteria and

preexisting conditions (which may not have existed at the time the original policy was purchased). NAIC standards are silent on some important issues of upgrading individual policies.

Grievance Procedures

The Health Security Act facilitates a grievance process that allows policyholders to formally contest insurance companies' decisions about their eligibility. The Act provides grants to states to, among other things, establish administrative procedure for the resolution of disputes about long-term care insurance.

At a minimum, a grievance process could help to resolve different interpretations of contractual obligations between policyholders and companies. Despite the prevalence of ambiguous provisions and eligibility requirements, most policies in our 1991 study did not have a formal grievance process. The policies that offered a grievance process indicated that the company would reconsider claims and would review materials submitted by policyholders to support their claims. NAIC standards are silent on the issue of a grievance process.

BETTER SAFEGUARDS NEEDED
FOR INSURANCE MARKETING

In addition to standards covering the content of policies, the Health Security Act contains standards that address the marketing of policies. While the Act prohibits certain sales practices, it establishes no standards related specifically to the sale of policies to low-income persons. The Act merely provides authority for the Secretary to establish such standards.

Because long-term care insurance is expensive, it may not be appropriate for people with limited financial resources.⁴ But, companies that we reviewed did little to prevent the sale of long-term care insurance to people with low incomes. We also found that, in their marketing materials, the companies provided limited or no guidance to consumers on the affordability of long-term care insurance. Recognizing that long-term care insurance is generally not be an appropriate purchase for Medicaid recipients, NAIC model regulations include a requirement that long-term care insurance applications include a question to determine whether the applicant is covered by Medicaid.

⁴Long-Term Care Insurance: Better Controls Needed in Sales to People With Limited Financial Resources (GAO/HRD-92-66, March 27, 1992).

Incentives for Marketing Abuses

The Health Security Act requires the Secretary to develop regulations that establish limits on commissions. The high first-year sales commissions that agents can earn create an incentive for abuses in the sale of long-term care insurance. For example, until the practice was prohibited, large commissions associated with the initial sales of Medigap policies created undesirable incentives for agents to "churn" (that is, to sell) new policies to customers who already had insurance. Currently, NAIC has standards, like Medigap commission standards, that were presented as an option that states and insurers should consider adopting when they identify marketing abuses.

SUPPLEMENTAL INSURANCE

The Health Security Act defines supplemental insurance as a policy that provides coverage for services or items not included in the comprehensive benefit package or coverage for services or items that are included, but limited in amount or scope. It specifically excludes from the definition, Medicare supplement insurance (i.e., Medigap), long-term care insurance, hospital indemnity insurance, specific disease insurance, accident insurance. It also excludes cost sharing policies for which there are provisions in another section of the Act. So defined, it is unclear how large a market will remain for supplemental insurance, particularly if Congress

enacts legislation with universal health insurance coverage. Nonetheless, we have previously found abuses with this kind of insurance. Most of the work we have done on supplemental insurance concerns Medigap insurance, a type of supplemental insurance for which Congress has already enacted notable reforms. While the Health Security Act defines supplemental so as to exclude Medigap, it is nonetheless worthwhile to review briefly some of the problems that plagued Medigap because they are analogous to problems in supplemental insurance generally.

Prohibition of Duplicative Coverage

The Health Security Act prohibits the sale of any supplemental policy that duplicates any coverage provided in the Act's comprehensive benefit package or in Medicare Part B. This is similar to the current prohibition of the sale of duplicative policies in the Medigap market. The purchase by some consumers of multiple policies that duplicated coverage in other policies or even in Medicare was a persistent problem in the sale of Medigap insurance as consumers were confused about what they already had and what they needed.

Marketing Abuses Not Addressed
by the Administration Plan

The Administration plan does not deal with two types of abuses we have previously identified in supplemental insurance: churning and misleading sales practices.

As discussed above, some agents have persuaded consumers of Medigap policies to replace their policies unnecessarily, which resulted in new waiting periods during which policyholders are not covered for preexisting conditions. The NAIC Medigap consumer protection standards of 1989 required that replacement Medigap policies waive the waiting periods applicable to preexisting conditions (or other similar restrictions) to the extent such time was spent under the original policy. The Congress added this protection to federal law in OBRA 1990. To reduce the incentive to churn policies, NAIC's consumer protection standards limited agent's first year commissions to no more than 200 percent of the commissions for the second year. Although the Health Security Act section on long-term care insurance requires the Secretary to develop regulations that establish limits on commissions, there is no such restriction with regard to supplemental insurance.

Finally, there have been problems with sales tactics used to make initial contact with older consumers. Some companies use "cold-lead" cards that solicit information from consumers without

disclosing that the purpose of follow-up calls is to sell insurance. Some agents have used high pressure sales techniques, which are also now prohibited for Medigap insurance.³ The Health Security Act section on supplemental insurance does not appear to address this issue, although it is covered for long-term care.

Specific Disease and Hospital
Indemnity Policies Not Covered

While the section on supplemental insurance in the Health Security Act provides important protection for consumers, it does not include specific disease and hospital indemnity insurance. Benefits from these types of policies typically are payable directly to the policyholder and may be used for any purpose. Hospital indemnity policies generally pay a fixed amount, such as \$50, for each day the insured is in the hospital up to some maximum. Specific disease policies (sometimes called "dread disease" policies) cover only particular diseases, typically cancer, and pay a fixed amount for each day of hospitalization or outpatient treatment.

Dread disease and hospital indemnity policies provide narrow protection. They provide limited, fixed benefits without provisions for inflation, and benefits are paid only when the

³Medigap Insurance: Better Consumer Protection Should Result From Changes to Baucus Amendment (GAO/HRD-91-49) March 5, 1991

consumer is confined to a hospital or contracts the covered disease. Moreover, they offer a poor return to policyholders. Our review of policies found they had an average loss ratio of 53 percent.⁶ Assuming limited funds for health insurance, a consumer's best course of action would be to purchase coverage for the broadest set of possible contingencies.

CONCLUSION

We have testified before your subcommittees on previous occasions and reported on problems in the market for long-term care insurance. We have advocated that consumers be afforded the protection of disclosure standards, an inflation protection option, clear and uniform definitions of services, facilities and eligibility criteria, grievance procedures, nonforfeiture benefits, options for upgrading coverage, and a sales commission structure that reduces incentives for marketing abuses. We believe that the section of the Health Security Act dealing with long-term care insurance generally incorporates these protections.

⁶A loss ratio is the ratio of benefits paid to total premiums paid. Thus, a ratio of 53 percent means that, on average, 53 cents of each premium dollar was returned to a policyholder in benefit payments or used to increase reserves against future claims. The portion of earned premiums that is not returned to policyholders is available for marketing, administration, and profit. Health Insurance: Hospital Indemnity and Specified Disease Policies Are Of Limited Value (GAO/HRD-88-93, July 12, 1988).

Finally, while the Health Security Act addresses supplemental insurance, it is less comprehensive and offers less protection to consumers than is the case with long-term care insurance.

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This concludes my statement. I would be happy to answer any questions.

APPENDIX I

APPENDIX I

GAO REPORTS ON
LONG-TERM CARE INSURANCE AND SUPPLEMENTAL INSURANCE
1988 - 1993

Health Insurance: Hospital Indemnity and Specified Disease Policies Are Of Limited Value (GAO/HRD-88-93, July 12, 1988).

Long-Term Care Insurance: Proposals To Link Private Insurance and Medicaid Need Close Scrutiny (GAO/HRD-90-154, Sept. 10, 1990).

Medigap Insurance: Better Consumer Protection Should Result From Changes to Baucus Amendment (GAO/HRD-91-49, Mar. 5, 1991).

Long-Term Care Insurance: Risks to Consumers Should Be Reduced (GAO/T-HRD-91-14, Apr. 11, 1991).

Long-Term Care Insurance: Consumers Lack Protection in a Developing Market (GAO/T-HRD-92-5, Oct. 24, 1991).

Long-Term Care Insurance: Risks To Consumers Should Be Reduced (GAO/HRD-92-14, Dec. 26, 1991).

Medigap Insurance: Insurers Whose Loss Ratios Did Not Meet Federal Minimum Standards in 1988-89 (GAO/HRD-92-54, Feb. 28, 1992).

Long-Term Care Insurance: Better Controls Needed in Sales to People With Limited Financial Resources (GAO/HRD-92-66, Mar. 27, 1992).

Long-Term Care Insurance: Better Controls Needed to Protect Consumers (GAO/T-HRD-92-31, May 20, 1992).

Long-Term Care Insurance: Actions Needed to Reduce Risks to Consumers (GAO/T-HRD-92-44, June 23, 1992).

Long-Term Care Insurance Partnerships (GAO/HRD-92-44R, Sept. 25, 1992).

Long-Term Care Insurance: Tax Preferences Reduce Costs More For Those in Higher Tax Brackets (GAO/GGD-93-110, June 22, 1993).

Long-Term Care Insurance: High Percentage of Policyholders Drop Policies (GAO/HRD-93-129, Aug. 25, 1993).

Mrs. COLLINS. Ms. Bern.

STATEMENT OF NANCY BERN

Ms. BERN. Good afternoon, Madam Chairwoman and members of the subcommittees. Thank you for inviting me here to testify on the Health Security Act and its implications for long-term care insurance. My name is Nancy Bern. I am Vice President of Group Long-Term Care at John Hancock Mutual Life Insurance Company. I am here today on behalf of the Health Insurance Association of America, which represents 270 commercial carriers providing health insurance to 65 million Americans. I have been involved with this product at John Hancock for 10 years. I initiated the research into how our customers' financial needs would change as our society aged, and realized that the possibility of a long-term care need was a significant threat to the financial security of many Americans.

We designed and tested an insurance plan and issued our first policy in 1987. Our individual product has been approved in 50 States and we cover over 35,000 policyholders. We are the market leader in the rapidly expanded employer/group long-term care market, with over 90,000 persons insured. Our large employer/group clients include IBM, NYNEX, Westinghouse and Bank America. We believe that health reform efforts must promote a strong public/private partnership in the financing of long-term care services. We are encouraged that the President's proposal recognizes the importance of the private long-term care market.

We believe the long-term care financing system can best be improved through three strategies. First, individual responsibility for long-term care risk must be promoted through consumer education. Consumers must be made aware of the risk for incurring long-term care expenses, the wide array of services and settings available and the variety of high-quality insurance policies available to finance these services. Furthermore, all Americans must understand fully what is and what is not included in the Health Security Act.

Second, the growth of the private, long-term care insurance market is necessary for the success of the Health Security Act. This must be fostered by insuring high-quality options and by providing tax clarification for the purchase of coverage. Tax clarification would increase the affordability of private, long-term care insurance and lend additional legitimacy to this coverage.

Along with tax clarification, we support Federal standards for long-term care insurance products that would serve to build consumer confidence in private products. There is no inherent conflict between the growth of the private, long-term care insurance market and meaningful consumer protection. Both can simultaneously be achieved by well-crafted regulations. If the regulations are too onerous, however, they could work at cross purposes with the Health Security Act.

Third, we believe that public assistance must be provided for those who are unable to finance their own long-term care needs. We support a number of the long-term care provisions in the Health Security Act, including tax clarification, along with Federal consumer protection standards, consumer education grants, increased Medicaid asset threshold and increased Medicaid personal needs allowance.

We support these concepts, yet there are also a number of provisions in the Health Security Act that are of concern to us. For example, the proposed Act would allow States to exceed Federal standards. The increase in administrative costs resulting from multiple filings of the same product needlessly increases premium costs and may discourage carriers from marketing in multiple States, thereby limiting consumer choice.

The proposed law places arbitrary limits on premium increases. We oppose arbitrary premium caps and do not believe that such limits ensure that rates are set correctly in the first place. The most effective protections include measures which assure that initial premiums and potential increases are determined appropriately on the basis of actuarial data and ensure that a carrier's long-term obligations will be met.

The proposed Act directs HHS to establish limits on agent insurance commissions. Blanket restrictions on sales commissions do not distinguish between agents who are selling in an ethical way and those who are not. Agent problems should be dealt with directly by regulating agents' sales and marketing practices and extensive agent training and education, with strict enforcement penalties.

The Act would mandate nonforfeiture benefits on all policies. We support an offer of nonforfeiture benefits to all prospective policyholders.

In conclusion, President Clinton, in his comments, stressed the need for all Americans to take personal responsibility for their health needs. The Health Security Act should limit Government's assistance to those who cannot afford to provide for themselves. We believe that the cost sharing approach outlined in the Health Security Act should be revised so that only persons who cannot afford to purchase long-term care insurance would be eligible for some payment from the Government program.

Thank you for the opportunity to testify today.

[Testimony resumes on p. 225.]

[The prepared statement of Ms. Bern follows:]

Testimony by Ms. Nancy Bern,
John Hancock Mutual Life Insurance Company

Good afternoon Mr. Chairman, Mdme. Chairwoman and Members of the Subcommittees.

My name is Nancy Bern. I am Vice President of the Group Long-Term Care Division at John Hancock Mutual Life Insurance Company.

John Hancock first entered the long-term care market in 1987. We are deeply committed to marketing high-quality long-term care products in both the individual and employer group markets.

Our individual product, called *ProtectCare*, has been approved in all 50 states and has been purchased by over 35,000 individuals.

We are a major provider in the rapidly expanding employer group market, with over 86,000 persons currently insured. Our large employer group clients include such nationally recognized firms as:

IBM	NYNEX
BellSouth	Westinghouse
ES&W	BankAmerica
State Farm Insurance Companies	Dow Chemical Company
The Federal Reserve Bank	Black & Decker

I am here today on behalf of the Health Insurance Association of America (HIAA), which represents approximately 270 private insurance companies providing health insurance for 65 million Americans. About 62 percent of the long-term care insurance policies sold to date have been issued by member companies.

We welcome the opportunity to testify today on the issue of long-term care insurance in the context of the Administration's health care reform proposal, the Health Security Act.

We believe that comprehensive reform of our nation's health care system must include measures which promote a strong public-private partnership in the financing and delivery of long-term care services. We are encouraged that the President's proposal perceives the importance of private long-term care insurance and the need for the public to purchase such insurance. We have, for some time now, supported federal standards for long-term care products, as well as clarification of the federal income tax code as it applies to these products.

We agree that responsible regulation is in the best interest of both consumers and insurers. We believe that the insurance industry can and should play a pivotal role in meeting the nation's long-term care needs.

We are very willing to work with both state and federal regulators and policy makers to ensure that long-term care products are properly marketed, well-designed, affordable and meet the best interests of consumers. We feel that our mutual interests are best served by regulation that fosters the sale of quality products by reputable insurers.

It is imperative that any regulation allow John Hancock and other reputable insurers to respond to the evolving needs of both the individual and group marketplace. There is no inherent conflict between this need for flexibility and the protection of consumers from unscrupulous marketing practices. Both practices can be served by well crafted regulations and that is certainly our purpose in helping you achieve that goal.

We believe that the current health care reform debate provides an important opportunity to improve our country's long-term care financing system. We believe that this system best can be improved through three strategies.

- First, individual responsibility in planning for exposure to long-term care risk must be promoted through consumer education. Consumers must be made aware of the risk of incurring catastrophic expenses, the wide array of long-term care services and settings offered, and the numerous types of high quality private insurance products available to finance these services.
- Second, the growth of the private long-term care insurance market must be fostered by educating consumers about long-term care risk and product options and providing tax incentives for purchasing coverage. Tax clarification would increase the affordability of these products, lend additional legitimacy to this coverage, and help millions of Americans protect themselves against catastrophic long-term care expenses.

In conjunction with tax clarification, we would support establishing minimum federal standards for long-term care insurance products that would serve as a *seal of approval*, thereby building consumer confidence in private long-term care products. We believe that reasonable standards can protect consumers, promote the public interest, and promote the availability of quality, private long-term care insurance.

To the extent that such standards are too onerous, the effect could be to:

- increase the cost of long-term care insurance to a point where affordability becomes a problem,
- limit consumer choice in selecting affordable coverage and desired options, and
- reduce the availability of private long-term care products.

➤ Third, we believe that public assistance must be provided for those who are unable to finance their own long-term care expenses. Such assistance could take the form of enhancements to the Medicaid program. From a practical standpoint, however, regulations which have the end result of causing fewer persons to purchase long-term care coverage can only exacerbate state Medicaid costs.

We are pleased to see that the Administration has included several provisions in the Health Security Act which are consistent with our goals for strengthening financial protection for long-term care services and our strategies for achieving these goals. Such provisions include

- clarifying the tax status of long-term care insurance products;
- implementing minimum federal standards;
- authorizing consumer education grants for the development of long-term care information and counseling programs;
- increasing the Medicaid asset threshold for single individuals from \$2,000 to \$12,000; and
- raising the personal needs allowance for Medicaid recipients of institutional care.

Yet there are also a number of provisions in the Health Security Act that are of concern to us.

- ⇒ Section 2303 of the proposed Act would allow states to apply standards that exceed minimum federal standards. We believe that separate state requirements would limit consumers' access to a wide range of long-term care insurance products by stifling competition in the market. The increase in administrative costs resulting from multiple filings and approvals of the same product increase premium costs needlessly.
- ⇒ Section 2321 (c) (2) (D) of the proposed law places an arbitrary limit on insurer premium increases. We strongly support reasonable and justifiable insurance premiums which ensure that a carrier's long-term care obligations will be met. We share the Administration's concerns that consumers be protected from unwarranted rate increases. To that end, we believe that the most effective protections include measures which assure that initial premiums, and potential increases, are determined appropriately on the basis of actuarial data. However, we oppose the establishment of arbitrary limits on premium increases and do not believe that such limits would achieve the goal of ensuring that rates are set correctly in the first place. In addition, such limits have the potential to threaten insurers' abilities to pay future claims, which is certainly not in the best interest of consumers.

- Section 2324 (d) directs the Secretary of HHS to establish limits on long-term care insurance agent compensation. We do not support the use of agent compensation restrictions. We believe that problems with regard to lapse rates and replacement rates should be dealt with more directly by regulating agent sales and marketing practices and extensive agent training and education. Caps on commissions will not remove incentives for unwarranted initial sales or ill-advised policy replacements.

Blanket restrictions on sales commissions do not distinguish between agents selling in an ethical, responsible way and those who do not. The job of regulators is, and should continue to be, the effective enforcement of laws designed to weed out and prevent abuses — not the creation of laws which indiscriminately restrict appropriate competition across the board.

- Section 2326 (b) (2) would require an independent assessment of benefit eligibility by a qualified independent assessor selected by the insured. While we advocate that there be a strong appeals process, the insurer, or an organization affiliated with the insurer, is contractually obligated to manage an individual's long-term care needs so that the best care can be delivered most efficiently. Transferring the claim adjudication function to an outside party could expose the insurer to unintended claim liabilities.

- Section 2325 (e) would mandate nonforfeiture benefits in all policies. We support the concept that insurers must be required to offer all prospective policyholders, including group policyholders, a nonforfeiture benefit in the event of non-payment of premium. We do not support mandated nonforfeiture benefits in all policies because of the resulting premium increases associated with this benefit and questions regarding the value this benefit to those required to purchase it. We also dispute the validity of the reasoning behind a mandate for nonforfeiture benefits. Nonforfeiture benefits presumably are needed due to high lapse rates among long-term care insurance policyholders. Yet data collected by HIAA regarding lapse rates indicates that 50 percent of so-called lapses are due to deaths and internal or external replacements, i. e., consumers replacing existing coverage with a newer policy offered by the same carrier or with a policy offered by a different carrier.

A mandatory nonforfeiture benefit presents serious equity problems because it would substantially increase premiums for the majority of policyholders. An HIAA analysis based on data prepared for the NAIC indicated that, for a cohort of policyholders, only 30 percent would benefit from a reduced paid-up nonforfeiture benefit. The other 70 percent would be forced to pay additional premiums, but never receive any benefit.

- Section 2346 of the proposed Act would prohibit insurers from selling policies in states that do not have in effect an approved state regulatory program. We object to this provision which would penalize insurance carriers and consumers for state violations of federal law. We recommend that carriers be permitted to sell in any state as long as their products comply with minimum federal standards. Such a policy would encourage carriers to comply with minimum federal standards regardless of state implementation and enforcement activities. It would assure consumers access to a wide range of products that meet minimum federal standards.

We are encouraged to find that the language in the Health Security Act indicates that the state programs for home and community-based care are not intended as an entitlement program for individuals. However, we believe that the cost sharing approach outlined in Section 2105, Cost Sharing, (page 401), should be revised so that only persons who cannot afford to purchase private long-term care insurance would be eligible for some payment under the government program.

As currently worded, Section 2105 would extend benefits to many persons, at considerable public expense, who can afford private long-term care insurance, i. e., those at or above 400% of the poverty level, and probably many at lesser percentages of the poverty level, who may have substantial assets, but who do not have high incomes.

We have included more detailed, written comments on the Health Security Act, to accompany our oral testimony. These comments focus on our views on the importance of addressing long-term care financing issues as part of health reform and our recommendations on how long-term care financing improvements can best be accomplished.

Because the legislative language of the President's proposal has been available for only a short time, we hope that the Committee would be receptive to more detailed comments from John Hancock, HIAA and member companies after more thorough review.

We thank you for the opportunity to testify before you here today.

We commend the President for coming forward with an ambitious blueprint for reform of the nation's health care delivery and financing system. With approximately 37 million Americans currently without health insurance coverage, and health care costs consuming an ever greater share of the Gross Domestic Product, there can be no question regarding the imperative for comprehensive reform of our current system. Furthermore, we believe that comprehensive reform of our nation's health care system must include measures which promote a strong public-private partnership in the financing and delivery of long-term care services.

Uninsured people under the age of 65 represent only half the problem of inadequate health insurance protection. Almost 32 million Americans over the age of 65 also face the potentially devastating financial exposure to catastrophic expenditures for long-term care services. If our nation is serious about comprehensive health care reform, we must not abandon our nation's older and disabled American.

I. Long-Term Care in the Context of Health Care Reform

In his speech before Members of Congress on October 27, President Clinton reiterated the six fundamental principles on which his reform plan is based. At least four of these principles are relevant to long-term care reform:

- security,
- quality,
- choice, and
- responsibility.

These principles are among those included in HIAA's own Vision for Reform which we constructed last year. We would like to elaborate on these principles as they pertain to long-term care.

Security

The risk associated with older Americans incurring catastrophic long-term care expenses is equal to the risk to younger Americans of incurring costly primary and acute care expenses. The majority of those requiring such services are 65 or older. Approximately 7.1 million of the 32 million people age 65 and older need long-term care assistance. Seventy-nine percent of this group lives in the community with assistance and 21 percent live in nursing homes.

It is estimated that people age 65 face a 43 percent chance of entering a nursing home sometime during their lives. Of those who do enter nursing homes, 27 percent will stay for a year or more; 21 percent will experience lifetime stays of five years or more and incur enormous expenses to cover their care. Fully half of the age 85 plus population today needs some assistance with activities of daily living due to chronic illness or disability. Others need assistance with activities such as shopping, housekeeping and managing medication and finances. Since the over 85 age group is the fastest growing segment of our population, the needs of our nation's oldest citizens can only continue to grow.

The cost of long-term care services can be financially devastating. The average annual cost of nursing home care nationally is about \$36,000 and can be over twice this amount in certain areas of the country. Community-based services such as home health care also can impose significant financial burdens on the disabled, averaging \$10,000 to \$15,000 annually for someone who needs assistance several times a week.

Clearly, demographic and fiscal trends suggest the need for immediate action to address the long-term care financing needs of our nation's elderly. Despite heightened media attention in recent years to the long-term care needs of older Americans and their families, increased awareness has not resulted in a coordinated approach to our long-term care system. Delivery of these services remains fragmented and financing can be extremely complex. Furthermore, access to appropriate long-term care services often is blocked by inadequate financial protection.

The Medicare program was never intended to fund long-term episodes of illness for the chronically impaired. Furthermore, individuals must impoverish themselves to become eligible for Medicaid. Access to community-based support under Medicaid is limited and varies tremendously from state to state.

Public benefits for long-term care provide older Americans very little security. A survey published this year by the *Employee Benefits Research Institute (EBRI)* suggests that the American public is more confused than ever about what the federal government does and does not pay for long-term care expenses. In fact, an even greater percentage of 1993 *EBRI* survey respondents indicated that they believed Medicare would pay for their long-term care expenses than those responding to the 1990 survey.

These findings underscore the need for the federal and state governments to clarify their roles in financing long-term care and educating the public about how public and private sector responsibilities should be shared in funding this care. Only through such clarification and education will older Americans and their families find true security relative to their long-term care needs.

Individual Responsibility

In outlining the major principles underlying the Administration's plan for health care reform, President Clinton consistently has stressed the importance of individual responsibility by stating that "every American must assume responsibility to bring an out-of-control system under control and put funding on a fair and responsible basis." We believe this principle also must be applied to the long-term care side of the health care equation, and that the public and private sectors must share responsibility for financing long-term care services.

Clearly, given the magnitude of long-term care expenses, the government, private industry, and individuals all must share the costs of this burden. Both the federal and state governments are staggering under the pressure of increasing budget constraints. The cost of financing long-term care services, particularly in institutional settings, accounts for a large part of these constraints.

In recent years, the private insurance industry has spearheaded efforts to enhance financial protection for long-term care services. Currently, 135 companies offer long-term care insurance coverage. Since 1987, the number of individual policies sold has almost quadrupled, from 815,000 policies sold as of December 1987, to 2.9 million at the end of 1992. Of the policies sold in 1992, 32 percent were employer-sponsored policies. Moreover, the products themselves have changed significantly since first introduced to the market.

HIAA analyzed policies of the top fifteen long-term care writers, representing 80 percent of the market of all individual and group association policies sold in 1991. All products analyzed offered coverage for skilled, intermediate, and custodial nursing home care as well as home health care services. Thirteen of the fifteen companies offered adult day care, 60 percent covered alternate care, and 40 percent offered coverage for respite care benefits. All companies offered inflation protection, two-thirds offered nonforfeiture benefits, and many companies introduced new benefits.

It is important to note that consumers themselves are beginning to recognize the need to share responsibility for long-term care risk. A 1990 *EBRI* study indicated that 43 percent of the respondents felt that the federal government should accept primary responsibility for financing long-term care costs; only 6 percent felt that individuals should play the primary role. By 1993, only 29 percent of the respondents to *EBRI*'s long-term care survey felt the federal government should have primary responsibility for this burden. About 17 percent felt that individuals should play the primary role and another 13 percent felt that this should be a family responsibility.

Public opinion regarding willingness to pay for private long-term care insurance further supports the notion of individual and family responsibility for financing long-term care costs. About 65 percent of respondents indicated that they would purchase a policy from a carrier or employer. Almost 60 percent said they would purchase a policy for a family member, such as a spouse, parent, grandparent or child. In addition, respondents to the 1993 survey indicated a willingness to pay significantly more for private coverage than respondents to the 1990 survey. On average, 1993 respondents indicated they would be willing to pay \$927 annually for long-term care insurance. Respondents to the 1991 survey said they would pay, on average, \$488 annually.

Choice

A fourth principle underlying the Health Security Act is choice. We believe that one of the most valuable benefits accruing to those who purchase private long-term care insurance is choice — the ability to exercise control over which of the many community-based, residential and institutional services available they wish to use — and the ability to select which providers will deliver the services they choose.

While asset protection is an important reason for purchasing long-term care coverage, it is not the most important reason cited by those who buy policies. In a survey of 14,000 policies purchased in 1990, over half the respondents cited the most important reasons were preserving their independence (30 percent) and being able to afford needed care (20 percent). Protecting assets was cited by only 14 percent as the most important reason for obtaining coverage.

Clearly, individuals who are dependent on public assistance have few choices. The options they do have are conditioned to a large degree upon their state of residence and the state's economic status, since federal Medicaid matching funds are determined by the amount states are able to contribute. The development of innovative long-term care insurance plans, and access to this coverage, definitely expands the range of choices consumers have in meeting their long-term care needs.

Private long-term care insurance helps consumers preserve this choice. The continuous expansion of product benefit features has enabled consumers to select among a vast array of options relative to health care services and settings. For example, the HIAA survey revealed that 60 percent of the top fifteen sellers offer some type of alternate care benefit enabling consumers to receive nontraditional benefits, such as

- special medical care (e. g., services provided by special care units for Alzheimer's Disease);
- home modifications that enable consumers to remain at home instead of entering an institutional setting (e. g., modifications to bathrooms and kitchens, installation of wheelchair ramps); and
- care in adult foster homes and assisted living facilities.

Care management and caregiver training benefits also are being offered as a free-standing benefit by some insurance companies to help older people negotiate the complex web of long-term care services and settings and to train their caregivers to provide services enabling them to remain at home longer.

Quality

A principal goal of the Health Security Act is to improve the quality of care delivered to the American public. We believe that access to private long-term care insurance coverage enhances consumers' access to high quality care in at least two ways.

- First, private markets create greater incentives for providers to deliver high quality care in order to compete for clients.
- Second, by expanding the number of individuals paying privately for nursing home and community-based care, it will increase the amount of resources available to long-term care providers and assist them in maintaining high standards of care.

The expansion of private financing for long-term care services also reduces the drain on federal and state Medicaid budgets, a factor that has the potential to improve the adequacy of public reimbursement rates. Since Medicaid nursing home rates, on average, compensate providers for only about 70 percent of the actual costs of care, enhanced public reimbursement will help guarantee quality care.

II. Consumer Protection Standards

A. HIAA Consumer Protection Standards

HIAA and its members share the objective of policy makers and consumers - strong consumer protection laws and their full enforcement are needed for long-term care insurance. The market will not survive without them. To emphasize the need for unique consumer protection standards in the area of long-term care, in 1991, HIAA adopted a *Proposal for Long-Term Care Consumer Protection* which states the Goals of Long-Term Care Insurance Consumer Protection Regulations and proposes a Consumer "Bill of Rights". It identifies fundamental consumer rights for the purchasers of long-term care insurance. To back up the Bill of Rights, the proposal recommends a series of specific provisions in the areas of company, agent, and consumer education; disclosure; marketing practices; and policy benefit provisions.

We believe that the cumulative effect of government regulation should be to create an environment where the benefits of regulation outweigh their costs for consumers, the private sector and government. There are multiple provisions in the current NAIC Model Act and Regulation which we firmly support as appropriate consumer protection. These include:

- Requirement that individual policies be guaranteed renewable.
- Required offer of inflation protection.
- Prohibition against post-claims underwriting.

- Requirement that insurers establish auditable marketing standards for fair and accurate comparisons of policies, notification of limitations of coverage, and notification of availability of senior counseling programs, if one exists in the state.
- Prohibition against prior-hospitalization requirements.
- Required 30 day free look period with full refund of paid premiums upon return of policy within this period.
- Penalties on agents and insurers equal to three times the commission rate, or \$10,000, whichever is greater.
- Required delivery of detailed outline of coverage.
- Require policies to waive premiums while the insured is receiving nursing home benefits.
- Require insurers to establish and maintain meaningful update protection program offering policyholders new policy forms, improvements and coverages currently marketed by the insurer.

- Require insurers to base benefit eligibility criteria upon clinically-based empirical research in the area of disability and long-term care which accounts for the inability of the insured to perform an appropriate number of activities of daily living; or a similar level of disability as can be measured in terms of medical necessity; or a similar level of disability due to cognitive impairment.
- Require insurers to provide a clear and thorough written definition of the benefit eligibility criteria at the point of sale.
- Require insurers to inform an applicant about coverage decisions within 60 days after receiving a completed application and all necessary supporting documentation requested by the insurer.
- Require insurers to establish a thorough claims process which will be explained clearly in written form at the time a claim is filed.
- Require insurance departments and the NAIC to develop and specify minimum standards for establishing long-term care reserves. In addition, the NAIC should, working with insurers, develop criteria for evaluating insurer reporting data.
- Require states to report the finally adjudicated violations of a state's long-term care insurance laws or regulations.

B. Provisions in Health Security Act of Concern to HIAA

We support the President's intent to provide consumers high quality long-term care insurance products that assure consumers good value and adequate protection. We believe that the standards outlined above provide consumers with such assurances. We are concerned, however, that some of the standards contained in the Health Security Act are overly prescriptive and could act as a disservice to consumers. The concerns regarding specific provisions outlined below are based on a preliminary reading of the Act. Our comments are listed in order of their appearance in the legislation and are not ranked according to HIAA's priorities. (The page numbers after each section pertain to the Health Security Act.) We would appreciate the opportunity to provide the Committee with additional comments after we have analyzed this new legislation more extensively.

1. Section 2303 - Relation to State Law (p. 430)

This section would allow states to apply standards that exceed minimum federal standards.

We believe that separate state requirements would limit consumers' access to a wide range of long-term care insurance products by stifling competition in the market. Many long-term care insurance sellers have dropped out of the market due to the administrative burden and expense of filing different policies in fifty separate states. The increase in administrative costs resulting from multiple filings and approvals of the same product increase premium costs needlessly.

We recommend requiring insurance companies to file and receive approval for products only in their state of domicile and establishing a system for reciprocity in other states. Findings of compliance with minimum federal standards in the domiciled state would result in reciprocal approval by all other states. Such a policy would benefit consumers by

- increasing the number of carriers selling long-term care insurance products,
- expanding the type and number of products available to consumers,
- reducing the time lag between product filings and product availability in the market place and
- lowering the costs of products.

Furthermore, the broadening of competition in the market place would act as a powerful incentive for insurance companies to offer high quality, competitively priced products.

2. Section 2321 (b) - Uniform Terms (p. 435)

The Health Security Act would require insurers to use uniform terminology, definitions of terms, and formats in long-term care insurance policies.

We recognize that in order to provide meaningful benefits, policies must have clearly understood and well defined long-term care benefits. Several policy benefits, however, cannot be uniformly defined at this time. States vary widely in their definitions of licensed long-term care providers. Many types of noninstitutional services are evolving and there is no clear, much less uniform, definition developed. Beneficiaries could be harmed if definitions are "locked in" prematurely.

An example of the difficulty in having uniform definitions of terms pertains to assisted living facility benefits. Different states and provider organizations use different criteria in defining assisted living facilities. The type of services provided in these settings may range from meals and housekeeping only, to assistance with personal care. Regulations regarding the type of licensed or nonlicensed personnel required to provide services in these settings differ across states. Yet both of these care settings may be referred to as "assisted living".

We believe that it is important to maintain flexibility in defining certain terms in long-term care policies. This would allow companies greater latitude in offering a variety of benefits under long-term care insurance policies as both the insurance market, and the continuum of long-term care services, continue to evolve.

3. Section 2321 (c) (2) (D) - Premium Limitations (p. 437)

Under the standard outline of coverage for long-term care policies, carriers would be required to include a statement of the total annual premium and the portion of such premium attributable to each covered benefit, and any limit on annual premium increases.

We strongly support reasonable and justifiable insurance premiums which ensure that a carrier's long-term care obligations will be met. We share the Administration's concerns that consumers be protected from unwarranted rate increases. To that end, we believe that the most effective protections include measures which assure that initial premiums, and potential increases, are determined appropriately on the basis of actuarial data. However, we oppose the establishment of arbitrary limits on premium increases and do not believe that such limits would achieve the goal of ensuring that rates are set correctly in the first place. In addition, such limits have the potential to threaten insurers' abilities to pay future claims, which is certainly not in the best interest of consumers.

To assure that consumers are protected against unfair rate increases, and to promote the establishment of accurate rates at the outset of premium pricing, we recommend the following measures be taken:

- Prohibit insurers from selling policies with premium schedules based on attained age rating and durational rating.
- Require insurers to report their total long-term care premiums earned, claims incurred and loss ratios by state and in total to each state annually to provide states with the data needed to accurately assess the viability of premium pricing assumptions and methods.
- Require state insurance departments and the NAIC to develop and specify minimum standards for establishing long-term care reserves to ensure that adequate resources will be available to pay all claims.
- Require insurers to meet an expected loss ratio of at least 60 percent for individual policies. In addition, the NAIC, working with the industry, should determine the effects of lapse rates and underwriting practices on the pattern of loss ratios.
- Require insurers to provide rate guarantees for three years from the date policies are issued. In addition, rate increases should be limited to 10 percent to insureds over age 75 who have maintained coverage for 10 years or more.

- Require carriers to provide insureds the opportunity to reduce the level of benefits covered under the policy 90 days prior to a rate increase. This would enable consumers to maintain premium levels no higher than those in effect prior to a rate increase.
- Implement sanctions against insurers who demonstrate excessive rate increases. We recommend that in cases where carriers increase rates by more than 50 percent in any three year period, they should be prohibited from issuing policies for a period of two years in the state where rates were increased in excess of this limit.
- Permit state insurance commissioners to modify or waive rate provisions which could jeopardize solvency. For example, rates may need to be modified in the event of changes to federal and state laws or based on medical breakthroughs or new disabling diseases that would result in changes to mortality and morbidity patterns or assumptions.

4. Section 2321 (c) - Comparative Coverage (p. 440)

Under the outline of coverage, carriers would be required to provide consumers with comparative information regarding the availability of other private insurance including benefits offered under other long-term care policies offered by the insurer; additional benefits available under policies offered by other private carriers; and information regarding each public long-term care program administered by the state, Medicare programs under Title XVIII of the Social Security Act and each regional alliance operating in the state.

We support the right of consumers to receive accurate and thorough disclosure which enables a prospective insured to accurately assess the benefits and limitations of long-term care insurance coverage. We also support requirements that insurers provide consumers with a state-approved long-term care insurance consumer guide; the address and phone number of the state insurance department with the name and number of an insurer home office contact; and, if such a program exists, the name, address and phone number of a state-approved senior insurance counseling program. This information should be provided at the time of policy solicitation.

We are concerned, however, about requirements to provide additional information required under the Health Security Act, such as information about competitors' insurance products and detailed information about federal and state public programs, including benefits available under regional alliances. These reporting requirements are excessive, burdensome and, quite frankly, unachievable by any private or public sector entity.

5. Section 2324 (d) - Agent Compensation (p. 448)

Directs Secretary of HHS to establish limits on agent compensation.

We do not support the use of agent compensation restrictions. We believe that problems with regard to lapse rates and replacement rates should be dealt with more directly by regulating agent sales and marketing practices and extensive agent training and education. Caps on commissions will not remove incentives for unwarranted initial sales or ill-advised policy replacements.

Blanket restrictions on sales commissions do not distinguish between agents selling in an ethical, responsible way and those who do not. The job of regulators is, and should continue to be, the effective enforcement of laws designed to weed out and prevent abuses — not the creation of laws which indiscriminately restrict appropriate competition across the board.

Long-term care insurance is still a relatively new market around which a great deal of consumer ignorance and misunderstanding still exists. The sale of this product involves educating consumers about the need for long-term care protection, the service options available and individual product options. Dedicated agents should not be penalized for spending the extra time necessary to assist consumers in understanding their long-term care needs and options.

6. Section 2326 (b) (2) - Independent Professional Assessment (p. 463)

This section would provide for an independent assessment of benefit eligibility by a qualified independent assessor selected by the insured.

We object to an independent third party determining eligibility for private policies. While we advocate that there be a strong appeals process, the insurer, or an organization affiliated with the insurer, is contractually obligated to manage an individual's long-term care needs so that the best care can be delivered most efficiently. Transferring the claim adjudication function to an outside party could expose the insurer to unintended claim liabilities.

7. Section 2325 (e) - Mandatory Nonforfeiture (p. 457)

This section would mandate nonforfeiture benefits.

We support the concept that insurers must be required to offer all prospective policyholders, including group policyholders, a nonforfeiture benefit in the event of non-payment of premium. This should bear a reasonably consistent relationship by issue age and duration. We do not support mandated nonforfeiture benefits in policies because of the resulting premium increases associated with this benefit and questions regarding the value this benefit to those required to purchase it. We also dispute the validity of the reasoning behind a mandate for nonforfeiture benefits. Nonforfeiture benefits presumably are needed due to high lapse rates among long-term care insurance policyholders. Yet data collected by HIAA regarding lapse rates indicates that 50 percent of so-called lapses are due to deaths and internal or external replacements, i. e., consumers replacing existing coverage with a newer policy offered by the same carrier or with a policy offered by a different carrier.

A mandatory nonforfeiture benefit presents serious equity problems because it would substantially increase premiums for the majority of policyholders. An HIAA analysis based on data prepared for the NAIC indicated that, for a cohort of policyholders, only 30 percent would benefit from a reduced paid-up nonforfeiture benefit. The other 70 percent would be forced to pay additional premiums, but never receive any benefit.

According to an HIAA analysis of several of its members' long-term care products, a reduced paid-up nonforfeiture benefit increased the average annual premium for a 55 year old by 30 percent and, for a 60 year old, 20 percent. A nonforfeiture benefit which returns premium upon lapse raised the average annual premium for all ages by roughly 40 percent.

We also question the value of nonforfeiture benefits relative to the costs, and whether this strategy is the most effective vehicle for addressing the problem it is intended to cure --- voluntary lapse of insurance policies. Like life insurance, long-term care policies must be in force for a certain period of time before substantial benefits would accrue to the lapsed policyholder. Since most consumers who let their policies lapse do so in the first two years of coverage, there would be no value, --- only cost --- to requiring nonforfeiture benefits. Policyholders who maintain their policies would not need nonforfeiture protection. Finally, if educated consumers fully understand the benefits and limitations of nonforfeiture, they should be given the option to purchase such protection.

Because a nonforfeiture benefit adds significant additional cost to an insured's premium, we believe the benefit decision should rest with the insured. Given the choice, the insured might prefer to use the additional premium toward a higher daily benefit or more comprehensive coverage.

While we understand some of the arguments in favor of nonforfeiture, we encourage a standard which requires an "offer", with a written acceptance or rejection, just as has been done with inflation protection in the Health Security Act. It makes sense to give insureds choice and control over the cost of the benefits they purchase.

We feel that a more appropriate solution to the problem of policy lapses is to assure that consumers understand the need for and value of long-term care insurance protection, make educated choices about the purchase of products and that agents are well-trained to assist consumers in making prudent choices. HIAA supports agent education and includes such provisions in the HIAA Consumer Protection proposal. We also support the establishment of consumer education grants as specified in the Health Security Act.

8. Section 2346 - Failure to Have Approved State Program (p. 474)

This section would prohibit insurers from selling policies in a state that does not have in effect an approved state regulatory program.

We object to this provision which would penalize insurance carriers and consumers for state violations of federal law. We recommend that carriers be permitted to sell in any state as long as their products comply with minimum federal standards. Such a policy would encourage carriers to comply with minimum federal standards regardless of state implementation and enforcement activities. It would assure consumers access to a wide range of products that meet minimum federal standards.

III. Tax Clarification

We applaud the President for including tax clarification in his health care reform proposal. The current uncertain tax treatment of long-term care insurance is a hindrance to market acceptance and raises the price of the product. Clear tax rules will add legitimacy to, and further the establishment of, the private long-term care insurance market. The expansion of this market will have the parallel effect of reducing future costs to the public sector.

We are also very pleased that the Administration's proposal contains provisions which clarify the tax status of life insurance policies that accelerate benefits on account of terminal illness and long-term care. Since accelerated benefits were introduced in the early 1980's, we have sought clarification of the federal tax issues surrounding these products, which are now offered by more than 150 insurers and owned by approximately three million policyholders. As a result of this clarification, policyholders will be able to utilize their life insurance policies without adverse tax consequences to assist them in dealing with extraordinary medical expenses.

We also support the provision of tax credits for employed persons with disabilities. This provision would enable impaired taxpayers to take a non-refundable tax credit equal to 50 percent of certain impairment-related personal assistance services.

Determination of eligibility for long-term care benefits is based upon dependency in activities of daily living (ADL's) or cognitive impairment. The President's proposal defines the activities of daily living to be: eating, toileting, dressing, bathing, and transferring in and out of bed. We believe that dependency in three out of the five ADL's or cognitive impairment is the appropriate federal standard for the eligibility trigger. (Two out of five would be too broad, since bathing and dressing almost always are the first activities to go and they also almost always go at the same time.) The definition omits "maintaining continence", which is an ADL standardly used; perhaps this should be included in the list.

While we were pleased to note that the allowable daily maximum benefit amount excluded from taxation was increased from \$110/day in the President's September 7 Health Reform Draft to \$150/day in the Health Security Act, we believe that this amount is still too low. In many areas of the country, particularly large urban areas, \$150 is insufficient to cover the costs of nursing home care. We would suggest that the maximum benefit amount be set at \$250, indexed for inflation, to assure that consumers who live in higher cost urban settings are not penalized based on geographic location.

Many states now require companies to use a one-year preliminary term reserve. However, the IRS permits companies to deduct reserves no faster than over a two-year period. We feel Congress needs to conform the tax code to state regulatory requirements.

Many companies now permit covered employees to enroll their parents under their plan. To help encourage this trend, we recommend, for the purpose of long-term care insurance payments, that parents be treated as dependents.

Finally, the effective date of many of the tax clarifications in the Health Security Act is December 31, 1995. We see no reason it could not be sooner, perhaps December 31, 1994, to help consumers afford protection as quickly as possible.

IV. New Home and Community-Based Service Program

We have two concerns with the newly proposed national home care program.

- First, we believe that a far better use of limited tax dollars would be to target care to those unable to protect themselves. Scarce federal and state resources should be preserved for the needy rather than promising all Americans a small amount of coverage.

Individuals who can afford to purchase private insurance coverage should be encouraged to do so through education and tax incentives. Educational programs, such as those that would be available under the proposed consumer education grants, should assist consumers in understanding the risk of catastrophic long-term care expenses and options for covering this risk.

Tax incentives should be used to increase the affordability of long-term care products. Furthermore, the establishment of tax incentives would lend additional legitimacy to long-term care products and increase consumer confidence in such products.

- Second, we question the viability of this new community-based service benefit and are concerned that there is great potential for consumers to misconstrue their right to this benefit and overestimate the amount of protection afforded under this program.

Our primary concern regarding the viability of this program relates to funding. Even this modest benefit is projected to cost \$65 billion and funding for the program is contingent upon extremely ambitious projections regarding costs savings under current federal programs -- including \$65 billion in new Medicaid savings.

We also believe that there is great potential for the public to misunderstand the coverage provided. Although the legislation does not provide an entitlement to this new benefit, there is ample evidence of public misperceptions regarding federal long-term care benefits. To wit, the 1993 *EBRI* long-term care survey indicates that a higher percentage of respondents to this survey (45%) thought that Medicare would pay for their long-term care expenses than respondents to *EBRI*'s 1990 survey (35%) -- despite the tremendous media attention to the long-term care problem in recent years.

Further, we do not believe that the funding allocated to this program will provide substantial coverage for home care services to a broad segment of the population. Since income caps and age limitations are removed, we believe that many more individuals will qualify for benefits than states will have funding to cover, even under the enhanced federal match rate. In addition, while the program is targeted toward the severely impaired, we are concerned that the public will not understand the eligibility limitations placed on the program and will overestimate the coverage provided. In the absence of broad-based public education, it is extremely likely that consumers will underestimate their ongoing need for private coverage of these services.

We also are concerned that the structure of this program will lead to confusion among consumers regarding their coverage. The program calls for the use of both public and private financing to cover the same home and community-based services. Until an individual is severely disabled, his or her community-based services would be financed under a private insurance policy. Upon becoming severely disabled, he or she would discontinue private coverage and begin receiving public benefits for these services. Furthermore, except in the wealthiest states, such as New York, it is questionable whether consumers would receive the same level of community-based benefits under the new public program as they would have received under their private insurance policy. In such cases, the consumer might need to maintain the private insurance policy to supplement the cost of services not provided under the public program.

The structure of the new home care program hardly creates the kind of "seamless" system touted by the Administration. To the contrary, it creates the potential for tremendous confusion on the part of consumers. It also presents challenges to insurance companies attempting to structure a private insurance benefit that coordinates with public coverage.

If each state has the discretion to establish its own benefit package for home and community-based services, insurance carriers will need to develop a different home care benefit for every state to coordinate with public benefits. Furthermore, to maintain currency with state programs, carriers would have to update their home care benefits each time states modified their programs, restructure premiums to account for changes in actuarial assumptions and pricing, and refile new products with state insurance departments.

We are concerned that the administrative and financial burdens placed on carriers under the Administration's proposed program structure would force carriers to reconsider the viability of offering home care coverage. Surely, this is not in the best interest of consumers who consistently have expressed their preference for this type of coverage in national surveys. For these reasons, we strongly recommend that eligibility for the new home and community-based care service program be income-related and that private insurance be encouraged for those who can afford this coverage.

Conclusions

We applaud the President for introducing an ambitious blueprint for reform of our nation's health care delivery and financing system. We further are encouraged that he recognizes the need to address long-term care in his vision for reform through the establishment of a strong public/private partnership in long-term care financing. Clearly, the magnitude of the financing dilemma suggests the need for such a partnership to ensure access to long-term care services for all Americans.

We believe that our current long-term care financing system can best be enhanced through three strategies.

- Individual responsibility in planning for long-term care risk must be promoted through education.
- The development of a strong private long-term care insurance market can be facilitated through tax incentives that increase the affordability of long-term care products and lend legitimacy to this market. Federal standards, in conjunction with tax clarification, can further increase consumer confidence in long-term care products and spur market growth.
- Finally, for those who are unable to finance their own long-term care services, a humane program of public assistance must be provided.

We are pleased that the Administration has included several provisions in the Health Security Act which are consistent with HIAA's goals and strategies for promoting long-term care protection. These provisions include clarifying the tax status of long-term care products; establishing federal minimum standards; authorizing consumer education grants for long-term care information and counseling; and amending the Medicaid program to allow for higher asset thresholds and my raising the personal needs allowance for the institutionalized.

The Health Insurance Association of America would like to serve as a resource to Members of Congress and the Administration in refining proposals to improve our country's system for financing long-term care services. We stand ready to assist the Committee in this process in the coming months.

Mrs. COLLINS. Thank you. Ms. Spencer.

STATEMENT OF KATHELEN V. SPENCER

Ms. SPENCER. Thank you, Madam Chairwoman, Mr. Chairman and members of the committee. My name is Kathelen Spencer, and I am Senior Vice President and Deputy Counsel of AFLAC. AFLAC is the world's leader in the supplemental health insurance market. We sell supplemental insurance products, with our major markets being in the United States and Japan. We are pleased to have the opportunity to testify before you today.

On behalf of AFLAC, I would like, at the outset of my testimony, to publicly commend President Clinton and his administration for having the courage to address the question of how our country can best provide its citizens with adequate health care. AFLAC would also like to commend the members of this committee and others in Congress who have led and supported efforts to formulate effective legislation to deal with this issue. We are particularly appreciative of this opportunity to participate in the process.

We have been asked today to comment on the President's health care reform proposal, as it relates to private voluntary supplemental health insurance. Supplemental insurance is purchased by individuals for specific protection which they want or feel they need and which goes beyond the protection provided for them by their regular health insurance policy. AFLAC sells a broad range of supplemental health insurance products, including Medicare supplement, hospital indemnity, accident and disability, long-term care, cancer and hospital intensive care. Our products are designed, priced, marketed and in fact to serve as supplements to major medical-type basic coverage.

They are designed to provide extra cash benefits to help with the non-covered medical expenses, as well as the non-medical costs of illness. Consistent with both AFLAC's and the administration's views on health care reform, all products sold by AFLAC are guaranteed renewable for life, fully portable and community rated on a statewide basis.

As we read the President's proposal, it would not inhibit anyone's right to purchase most kinds of private supplemental health insurance policies. In fact, section 1421 specifically exempts certain kinds of voluntary private, supplemental health insurance policies from coverage under the bill. These include long-term care, specific disease policies, hospital and nursing home indemnification policies and accident insurance. They would, of course, continue to remain subject to all existing State and Federal laws and regulations.

While there is uncertainty as to how the final version of the Health Care Bill will look, we applaud the President for taking steps to put to rest fears, by making it clear from the outset that Americans will continue to have the right to make their own judgments as to the purchase of additional coverage. Independent research with our own customers shows an overwhelming majority strongly favor the continued right to buy supplemental coverage under health care reform. This confirms what we all know to be a fact.

Americans highly value the right of self-determination, which extends to the right to make judgments based on their own individual

circumstances as to the amount of insurance that they need. From both the public policy standpoint and a common-sense, political one, this was a good decision. As the First Lady mentioned in her speech last night, people are generally supportive of change, but grow apprehensive when wondering how it will particularly affect them. This step should allay concerns many consumers may have about how they will be affected.

I would like to clarify for the record one point, which we believe is frequently misunderstood in regard to supplemental insurance. Prior to 1990, there were some unscrupulous companies which apparently sold or oversold duplicate Medigap policies to senior citizens. AFLAC, as well as many other legitimate companies, never participated in these tactics. We would like to state, for the record, that we absolutely abhor such practices which only serve the purpose of victimizing unsuspecting senior citizens.

We would like to state on the record further that we commend Congress and this committee in particular for taking the steps to write into over 90 specific provisions to strengthen the law which protects senior citizens from these practices. However, it would be a mistake to confuse those practices with our topic today, that of supplemental insurance policies that are generally sold to the public at-large, and are not targeted to senior citizens. It is these policies which we believe the public should have the unfettered right to purchase.

For example, most of AFLAC's policies are sold to working people through payroll deduction. The average age of issue for AFLAC's specific disease policies is 42. However, we would hope that the committee would do nothing to inhibit or prohibit the rights of these people to buy or continue to buy these policies after they become senior citizens, as long as they see fit. It is precisely at this point in their lives when they become most vulnerable to the kind of diseases for which they have purchased protection. We strongly agree that the—with the Clinton Plan that individuals are in a superior position to evaluate the needs and risk.

My time is up. We have submitted, as a part of the record, Madam Chairwoman, a Johns Hopkins Center of Hospital Finance and Management Study, which I would point out does have some information about the role of private insurance in markets which already have national or social health insurance. I thank you again for the opportunity to testify today.

[The prepared statement of Ms. Spencer follows:]

TESTIMONY BY

KATHELEN V. SPENCER
SENIOR VICE PRESIDENT, DEPUTY COUNSEL
AFLAC (AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS)

before a joint hearing of the

SUBCOMMITTEE ON COMMERCE, CONSUMER PROTECTION, AND
COMPETITIVENESS

and the

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

of the

ENERGY AND COMMERCE COMMITTEE

of the

UNITED STATES HOUSE OF REPRESENTATIVES

on

November 9, 1993

Madam Chairwoman, Mr. Chairman, and Members of the Committee, my name is Kathelen Spencer. I am Senior Vice President, Deputy Counsel for AFLAC, American Family Life Assurance Company of Columbus (Georgia).

By way of background, our Company, AFLAC, was founded in 1955, and is the world's leader in supplemental insurance. We operate in all 50 states, and sell a broad range of products, including Medicare supplement, hospital indemnity, accident and disability, long term care, cancer, hospital intensive care and life insurance. Our products are designed, priced and marketed as supplements to comprehensive health benefit coverage. They are designed to provide extra cash benefits to help the insured pay for non-covered medical expenses, as well as the non-medical costs of illness.

In the U.S. in 1992 we paid over \$290 million in claims. Through independent research we have confirmed a high level of satisfaction on the part of our claimants, with over 90% stating

that they would recommend our insurance. The high cost of illness, along with independent verification with our policyholders, supports the fact that supplemental insurance can be a valuable component in many individuals' insurance portfolios.

AFLAC insures approximately 38 million people worldwide with international operations in Japan, Canada, United Kingdom, Taiwan, and Hong Kong. We insure over 22% of all Japanese households.

AFLAC has been designated as the safest insurance company in America by Financial World Magazine for the last two years and is rated A+ Superior by Best's Insurance Reports.

AFLAC believes that reforms are necessary to guarantee all Americans the right to basic health care and to help control the rise in medical costs. We are particularly supportive of reform with respect to universal coverage and portability. We also believe Americans should be guaranteed the right to purchase the best medical services available and to supplement their basic health care benefits with the amount of insurance they judge to be appropriate to cover their financial obligations. Consistent with AFLAC's and the Administration's view on health care reform, all products AFLAC sells are guaranteed renewable for life, fully portable and community rated on a state-wide basis.

On behalf of AFLAC, I would like, at the onset of my testimony to publicly commend President Clinton and his administration for having the courage to address what is clearly one of the most important issues we will face in our lifetime: how our country can best provide its citizens with adequate health care. AFLAC would also like to commend the Members of this Committee and others in Congress who have led and supported efforts to formulate effective legislation to deal with this enormous task. We are particularly appreciative of this opportunity to participate in this hearing and we would hope and trust that we may continue working with you throughout this process.

The purpose of my appearance before the Committee is to provide comment on the President's health reform proposal, specifically as it relates to supplemental health insurance.

With the ongoing debate over how the final version of the health care bill will look, there is predictably a certain amount of concern and apprehension on the part of the American people with regard to how their own health insurance protection will be affected when this bill

becomes law. Wisely, at the outset of the legislative process, the Administration has chosen to provide the American people with the assurance that its new health plan would not interfere with their right to purchase private supplemental policies. We certainly concur in this approach. The mere fact that the American people will have the comfort of knowing that they will continue to have the unimpaired right to keep the supplemental coverage they have -- or to purchase additional coverage if they so choose -- will do much to allay any apprehension they may have with regard to national health care reform.

Madam Chairwoman, preserving people's continual right to purchase private supplemental insurance coverage is commendable for two reasons, both of which I am sure are important to the Members of this Committee -- (1) it is good public policy, and (2) it is good politics.

Preserving the right to purchase supplemental insurance is good public policy because people should have the right to purchase additional coverage. It is good politics because people want the right to purchase additional coverage.

Private supplemental insurance has developed in the United States in order to meet the ever changing needs of Americans. These policies are widely available on both an individual and voluntary payroll deduction basis. Private supplemental insurance is normally purchased by individuals for specific protection which they want or need which goes beyond the benefits provided for them by their regular health insurance.

Private supplemental policies are not unique to our system. Earlier this year AFLAC commissioned a study by the Johns Hopkins Center for Hospital Finance and Management on private supplemental insurance in three countries which already have health care systems that typify the general systems which have been frequently mentioned as possible models to restructure the delivery systems for the United States -- the United Kingdom, Canada, and Japan. I have submitted a copy of this study for the record.

The Johns Hopkins Study noted that private supplemental insurance is purchased in all three of these countries for various purposes, including: gaining access for services not covered by the public system such as: certain procedures and amenities; additional medical and medical related services; and income maintenance during illness. Other purposes mentioned were gaining access to providers not participating in the system and to avoid compulsory system queues.

The Johns Hopkins Study also pointed out that in the United Kingdom, as well as other countries, the concept of cash benefits policies is rooted in a tradition of income protection during times of illness or disability. It noted that this concept actually predates basic health insurance policies.

President Clinton's health care reform proposal establishes two distinct markets for supplemental insurance, those sold within the health alliance and those sold outside the health alliance.

The first market place would include cost sharing and additional benefits policies. Cost sharing policies would be designed to provide coverage for deductibles, co-insurance and co-payments imposed as part of the comprehensive health reform package, much like Medigap policies do with the Medicare program today. Additional benefits policies would cover benefits not provided under the comprehensive package such as dental and vision care. Both the cost sharing and additional benefits policies would be sold through the health alliance to eligible individuals and would be required to meet strict standards and guidelines.

The second market place includes voluntary private supplemental insurance (hereinafter referred to as private supplemental insurance). Private supplemental insurance is designed to cover a broad range of expenses which are not necessarily specifically covered by any public or private health plan. Unlike cost sharing and additional benefits policies whose benefits go directly to pay for provider services, benefits from private supplemental insurance are paid directly to the individual. In addition to non-covered medical expenses, the money from these plans can be used to cover the non-medical costs of illness.

Section 1421 of the President's proposal, which deals with the imposition of special requirements on supplemental insurance, specifically exempts certain types of supplemental insurance from coverage of the new legislation, but would, of course, these policies would continue to be subject to existing Federal and state laws. These policies include long term care, specific disease policies, Medigap, hospital or nursing home indemnification policies, and accident insurance. Currently, AFLAC offers policies in each of these categories. We support this approach.

Although the President's package does not propose Federal regulation of private supplemental insurance, our segment of the industry is currently very tightly regulated by the states. State regulation includes approval of policy forms, rates, benefits, advertising and market conduct. With the exception of Medigap insurance, which was found to have problems with duplication and over selling by some unscrupulous companies, and which were addressed in OBRA 90 no significant problems have ever been identified with these types of products.

Madam Chairwoman, before I conclude my testimony I would like to clarify for the record one point which we believe is frequently misunderstood in regard to supplemental health insurance. Prior to 1990 there were some unscrupulous companies which apparently sold or oversold duplicate Medigap policies to senior citizens. AFLAC, as well as many other legitimate companies, has never participated in these tactics and we would like to state for the record that we absolutely abhor such practices which only serve the purpose of victimizing unsuspecting senior citizens.

We would also like to say on the record that we commend the Congress and this Committee in particular for taking the initiative to write into OBRA 90 specific provisions to strengthen the law which protects senior citizens from these outrageous practices.

However, the unscrupulous practices formerly associated with the victimization of senior citizens in connection with the sale of duplicate Medigap policies should not be confused, as they may have sometimes been in the past, with other supplemental insurance policies which are generally sold to the public at large and are not targeted to senior citizens. It is these policies which we believe the public should have the unfettered right to purchase.

For example, the average age of a purchaser of one of AFLAC's specific disease policies is approximately 42. Many of these purchasers continue to pay premiums on a guaranteed renewable policy for more than twenty years before they turn 65. We would hope that the Committee would do nothing to inhibit or prohibit the rights of these people to continue their policies after they become senior citizens -- for it is precisely at this point in their lives when they become most vulnerable to the kinds of diseases for which they have purchased protection. I might add that these policies generally provide for guaranteed payment of cash benefits over and above any other benefits to which they may be entitled.

We do not believe that it would be good public policy nor would it be fair to senior citizens to deny them the right to continued coverage from policies for which they have been paying for many years at this point in their lives. We hope that in making this distinction between Medigap policies and other kinds of supplemental health insurance policies that we have clarified any confusion which may have existed with respect to this issue.

Our interpretation of the President's proposal is that the bill appears to guarantee individuals the continued right to purchase any private supplemental insurance policies they need to cover their financial obligations. For that reason, AFLAC endorses the this principle as reflected in this portion of the President's bill.

Madam Chairwoman, Mr. Chairman, and Members of the Committee, again I would like to thank you for allowing us to participate here today and we shall look forward to working with you throughout this process. I will be happy to answer any questions that you may have for me at this time.

Executive Summary of Johns Hopkins' Report
on Private Supplemental Insurance

Introduction

A recent study conducted by the prestigious Center for Hospital Finance and Management at Johns Hopkins demonstrates that private supplemental health insurance plays a significant role in each of the world's three most common health care financing and delivery systems: the United Kingdom's National Health Service system, Canada's national health insurance system, and Japan's Social insurance system. Although each country has universal publicly-financed national health care coverage, supplemental private insurance is available in one form or another. President Clinton's health care reform package should consider these international examples of private supplemental insurance, and an important component to any U.S. plan should be the availability of such insurance.

United Kingdom's National Health Service

The United Kingdom's National Health Service (NHS) system provides comprehensive government-provided health care services, financed from general tax revenue. Most health care practitioners are salaried by the government and most health care facilities are owned by the government. Within the NHS system, individuals are assigned to a specific doctor based on the individual's residence.

Private insurance payments are an estimated 12% of the UK's total expenditure on health care. Currently, over 15% of the population carry some form of private supplemental health insurance; 7% purchase it as a substitute to the NHS coverage and do so primarily to gain access to private physicians and hospital services and to avoid the long waiting lines that are common in the public system in obtaining medical services. This insurance is generally obtained as an employee benefit. The remaining 8% purchase private supplemental cash benefit policies which provide income support during hospitalization. The concept of disability income support is deeply rooted in the United Kingdom and predates its health insurance system. Individuals directly purchase most of these policies.

Canada's National Health Insurance

Canada's National Health Insurance plan works as follows: The provincial governments design and administer their own health insurance plan, which must meet certain federal criteria to receive federal funding. Each plan provides certain minimum benefits and is financed through federal and provincial tax revenues. A Canadian citizen presents a province-issued insurance card for payment to a private sector provider when medical services are rendered. The provincial government pays the provider for such services.

Private insurance payments represent an estimated 7% percent of Canada's total expenditures on health care. (An additional 20% of the total is paid out-of-pocket). An estimated 60% or more of all Canadians carry some type of private supplemental insurance. Private supplemental insurance coverage is purchased either to provide additional coverage for services and amenities not included in the government plan or as a means to receive cash benefits during hospitalization. The former is generally purchased by employers and is provided as an employee benefit; the latter is generally purchased by small businessmen, professionals, and retirees. Canadian law prohibits private insurance policies from duplicating services provided by the provincial plans.

Japan's Social Insurance plan

Japan's Social Insurance plan, which is patterned after the German social insurance system, provides health care coverage for everyone through one of three insurance programs which serve different segments of the population. The system is financed primarily by mandatory payroll-based contributions from employers and employees. Each of the three programs is available through several public and private non-profit plans and each is required to provide a minimum package of benefits. However, the three programs require a range of coinsurance payments (some as high as 30%) and premium contributions, and provide for a range of out-of-pocket ceilings. Services are provided by private physicians in private clinics and private, non-profit hospitals.

Private insurance payments represent an estimated 16% of Japan's total expenditures on health care. At least 20% of Japanese citizens carry private insurance and it is generally purchased as a means to receive cash benefits, the most popular of which is disease-specific cash benefits policies. Like Great Britain, disability based income support has a deeply rooted history in Japan. Since 1986, Japanese citizens have been able to purchase private insurance coverage to provide additional services excluded by the public insurance program and to help cover copayment expenses.

Conclusion

Private supplemental insurance has developed in conjunction with universal coverage in the three most common national health care plans. Private supplemental insurance, in its various forms, has met health care coverage needs not satisfied by the respective national systems. Certain types of private insurance, such as cash benefits policies, have long, deeply-rooted traditions and actually predate most national insurance plans. Whatever health care package President Clinton proposes, he should provide individuals with the option to purchase private supplemental health insurance.

Mrs. COLLINS. Thank you. Mr. Willging.

STATEMENT OF PAUL WILLGING

Mr. WILLGING. Thank you, Madam Chairwoman.

I am Paul Willging, Executive Vice President of the American Health Care Association, which is the major trade association representing nursing and allied health facilities across the country. Through our 51 State affiliates, we represent over 70 percent of all nursing and allied health facilities. I want to commend you and this committee, Madam Chairwoman, for having focused attention on what is one of the most critical issues facing not just America's elderly, but all Americans.

I would like also to commend the President for having focused on the issue of long-term care and recognizing that acute care, health reform, health financing reform cannot move a pace without attention being devoted to long-term care as well. I would particularly applaud the president for having recognized that in looking at the issue of long-term care financing, one has to harness both public and private sector resources. Clearly, public funding alone cannot handle an issue this monumental.

I think we have seen what has happened already when one relies too extensively on public funding for a social good, and that is currently the use of public funds to in fact provide long-term care services through the Medicaid program. There is not a State in the Nation, Madam Chairwoman, which has not suffered fiscal crisis over the past few years. There is not a State in the Nation that has not seen the growth of the Medicaid program propelling those fiscal crises. There is not a State in the Nation that hasn't seen the geometric growth of long-term care within the Medicaid program essentially taking a large role when it comes to those crises.

Clearly, we need to harness public and private resources together, because the future will not change. If we do not make some dramatic change in long-term care financing, the current stream of revenues into nursing facilities, 44 percent public, will grow to 67 percent public by the year 2025. In the demographics, the aging of America will push that even more dramatically. Those Americans most in need of nursing home care, those 85 years of age and older, 25 percent of whom reside in nursing homes, that population group, by the middle of the next century, will grow by 700 percent. Seven hundred percent is a phenomenal growth rate which will not, in fact, support continued reliance on public funding as the way to deal with long-term care.

What can the Government do? It can do much of what the President has proposed in his health reform proposal. He is looking to the question of education. He is looking to the question of consumer protection. He is looking to the question of tax clarifications. What it gets down to, Madam Chairwoman, is value, perceived value. People will buy long-term care insurance if they perceive it to be valuable to them.

When 50 percent of Americans still assume if they need long-term care, Medicare will pick up the tab, we obviously do not have value in the mind of the American consumer. If we still do not know whether or not the premiums paid for long-term care insurance, or the benefits provided by long-term care insurance will be

or will not be taxable, it is difficult to create the impression of value.

The committee took a courageous step in the budget debate this year when it chose to put added prohibitions on the asset transfer problems we have seen. As long as Americans think they can artificially impoverish themselves by moving assets into protected categories, value will not be perceived. Finally, I think we do need to provide consumer protections. The American Public, when it buys long-term care insurance, has got to know what it is buying. It has got to know what it is paying and it has got to know that when it needs the benefit, the benefit will be there.

Clearly, there have been issues as to the affordability of long-term care insurance. Unfortunately, that issue is largely been debated in a political context. Those who choose not to see the use of private sector resources will often posit assumptions that would lead one to believe that Americans cannot afford long-term care insurance. I consider many of those assumptions to be self-fulfilling prophecies.

That is not, however, to say that cost is not an issue. Obviously, long-term care insurance can be and is price-elastic. The more it costs, the less likely certain people will feel they can afford it. As we support at the American Health Care Association consumer protections, we do caution that let us not so protect the consumer that we price the product out of his or her reach.

I look, for example, to the issue of nonforfeiture. We strongly support the offer of nonforfeiture provisions and long-term care insurance. We strongly oppose the mandate that nonforfeiture be a part of long-term care insurance.

I have a long-term care insurance policy. I pay about \$500 a year for that policy. I chose not to want nonforfeiture because I did not want to pay the additional 50 percent on premium that would have cost me. I do not know to what extent I am being protected as a consumer by being told I have to purchase a benefit within that policy that I choose not to purchase, especially if it is going to cost me an additional 50 percent in premium. So, protections are important. Let's not protect ourselves to the extent that this critical new wave, this critical new product, this critical new service, long-term care insurance, is priced out of the market. Thank you very much.

[The prepared statement of Mr. Willging follows:]

PAUL WILLGING, Ph.D

Executive Vice President

American Health Care Association

Madam Chairman, Mr. Chairman, members of the Subcommittees, I am Paul Willging, Executive Vice President of the American Health Care Association (AHCA). The more than 11,000 long term care facilities that make up our Association care for more than one million elderly, frail, and/or disabled residents. On behalf of AHCA's members, and the residents for whom our members care, thank you for the opportunity to represent them at this important hearing.

The American Health Care Association applauds the President and First Lady for putting forward comprehensive health care reform legislation -- comprehensive in that it that begins to address the need for long term care financing reforms. Likewise, AHCA commends your work to move from these proposals to practical programs. I sincerely hope that AHCA can contribute to the successful outcome of that work.

The Clintons' legislative proposal, the "Health Security Act," includes a number of significant long term care provisions. Some of these AHCA wholeheartedly supports, some concern us, and others we are still struggling to understand. Today, I will do my best to share both AHCA's praise and doubts concerning the various long term care provisions of this important proposal. My testimony will emphasize AHCA's beliefs that:

- * the private sector must play a significant role in supporting long term care;
- * private long term care insurance can be an effective engine in moving toward a strong private/public partnership; and
- * there are things that the federal government must do -- and must not do -- to help make a long term care private/public partnership work.

THE NEED FOR CHANGE IN LONG TERM CARE FINANCING

Our society, individually and collectively, has not made adequate provision for financing the costs of long term care for a growing elderly population with growing needs. Individuals and families are not saving for, or insuring themselves against, the costs of long term care. The federal/state Medicaid program is stretched to the breaking point. Families and governments are going broke.

Absent action to address these problems, our growing elderly population will come to rely much more heavily on Medicaid to pay for long term care. Currently, Medicaid accounts for approximately 48 percent of all long term care payment -- and about 67 percent of all long term care patient days -- in the United States. If current trends continue unchecked, Medicaid will be called upon to bear an ever increasing share of the nation's long term care costs in the decades to come. But these current trends cannot continue. Federal and state budgets -- already strained badly by current Medicaid long term care

obligations -- cannot bear such costs. Nor would the elderly be well served by an overwhelmed Medicaid program.

Recent (February 1993) Gallup Organization survey results indicate that more than three-fourths of Americans (76%) agree that "government should pay the cost of nursing home care only for those who cannot afford it." In order to meet the nation's growing long term care needs without both emptying the public purse and driving down the quality of care, our society cannot afford to rely solely on government. Instead we must encourage and enforce an expectation of personal responsibility on the part of those with access to the means to plan for and pay for potential long term care costs. Government can -- and must -- help in this effort by working to see that individuals have the information and resources they need to take on personal responsibility for meeting their long term care needs.

LONG TERM CARE COSTS ARE IMPOVERISHING SENIOR CITIZENS

Most elderly Americans are aware neither of the magnitude of long term care costs nor of the limits of government assistance. PrinterError: Americans do not foresee needing long term care. Most probably do not realize how costly months or years of long term care can be. Many Americans wrongly assume that government programs or acute care health insurance will cover the costs of any long term care services they might need. For all these reasons, individuals and families face long term care costs for which they have not planned and which they cannot afford.

The cost of long term care can quickly wipe out the savings even of those who have worked and saved for a lifetime. Currently, the cost of one year of nursing home care is more than three times the average annual income for an elderly American. The nation's current long term care policy, however, does not promote personal planning, saving, or the purchase of insurance against the financial risk of long term care costs. Nor does our nation provide comprehensive social insurance against the financial catastrophe of long term care costs. Rather, it is only once a long term care recipient has been impoverished that government assistance is available through Medicaid -- a "welfare" program.

MEDICAID IS IMPOVERISHING THE FEDERAL AND STATE GOVERNMENTS

According to the Health Care Financing Administration (HCFA), total Medicaid spending (state and federal) has doubled over recent years -- from \$48.2 billion in FY 1987 to \$96.4 billion in fiscal year 1991. HCFA expects Medicaid to cost \$141 billion in FY 1993. If current trends hold, HCFA projects that total Medicaid spending could rise to \$230 billion in FY 1997.

In recent years, the controversy in California over the cost of nursing home reform, the number of court battles over state obligations for adequate Medicaid reimbursement, and the protracted battle over "provider specific taxes" well illustrate

the strain that Medicaid is putting on state and federal resources. This strain jeopardizes the accessibility and quality of both acute and long term care for those who must depend on Medicaid. Clearly, if current long term care needs have stretched the federal and state budgets to their limits, future needs will overwhelm our current arrangements for long term care financing. Therefore, the nation will have to look to sources other than current government programs for additional resources to meet the future long term care needs of an aging population.

THE ROLE OF PRIVATE LONG TERM CARE INSURANCE

Results from a March 1993 Gallup Organization survey indicate that a large majority (79%) of Americans agree that "to keep government costs as low as possible, private insurance should play a more active role in paying for nursing home bills for most Americans."

The mechanism of private insurance, so useful in protecting individuals and families from such costly misfortunes as accidents and illness, has great potential for marshalling private sector resources to meet long term care costs. Insurance offers a very good means to preserve an individual's choice from among various long term care arrangements and competing providers. Its expanded use would make an appropriate private/public long term care partnership viable. It has great potential for lessening the long term care cost burden that the graying of America will otherwise put on the federal government and the states.

To date, private insurance accounts for less than two percent of all payments for long term care services. AHCA is confident, however, that with appropriate changes in federal policies private long term care insurance can and will take on a larger role in meeting long term care costs. In order to expand the role of private insurance, a number of things must change. Chiefly, long term care insurance policies must have value to consumers. In order to enhance the value of long term care insurance to consumers, Congress and the Administration must:

- * establish federal standards and consumer protections;
- * clarify the federal tax treatment of long term care insurance; and
- * conduct public education to help Americans understand the risk of, cost of, and means of financing long term care.

Another key step toward realizing the potential of private long term care insurance has already been taken. This Congress -- and especially this Committee -- deserve recognition for an important long term care financing reform enacted earlier this year. Thanks largely to the Subcommittee on Health and the Environment, OBRA '93 included provisions for closing loopholes in the current

Medicaid program that permit affluent elderly to claim benefits meant for the indigent. These provisions are crucial to the establishment of the appropriate balance between public programs and private resources in financing long term care.

FEDERAL STANDARDS AND CONSUMER PROTECTIONS

Appropriate federal standards and consumer protections for long term care insurance would inspire consumer confidence; foster the growth of the private long term care insurance market; and make sure that elderly consumers are spared the kinds of problems that once plagued the "Medigap" insurance business. As providers of long term care, AHCA's members do not benefit from private insurance policies that do not provide adequate coverage. Providers do not benefit from sales practices that lead individuals to purchase inappropriate policies or policies that they cannot afford to pay for. Accordingly, AHCA supports federal standards to ensure appropriate policy design and sales practices.

At the same time, providers cannot benefit from private insurance policies priced out of the reach of consumers by federal regulation that is too heavy-handed. Therefore, AHCA recommends strongly that proposed federal standards be balanced by considerations of affordability.

CLARIFICATION OF THE TAX STATUS OF LONG TERM CARE INSURANCE

AHCA supports treating long term care insurance contracts in the same manner as accident or health insurance contracts. Specifically, AHCA supports the following clarifications to the tax treatment of long term care insurance:

- * treatment of long term care insurance contracts in the same manner as accident or health insurance contracts;
- * treatment of amounts received under long term care insurance contracts for long term care services in the same manner as amounts received for personal injuries or sickness;
- * treatment of employer plans providing long term care services in the same manner as accident or health plans;
- * treatment of life insurance benefits paid to a terminally ill individual in the same manner as death benefits;
- * inclusion of long term care options as preferred employee benefits in employer programs, including cafeteria plans; and
- * codification of the allowance of tax deductions for additions to an insurer's long term care insurance reserves.

LONG TERM CARE PROVISIONS OF THE HEALTH SECURITY ACT

The long term care provisions of the Clinton Administration's proposed Health Security Act call for:

- * the expansion of home- and community-based long term care services;
- * changes in eligibility for Medicaid community and institutional long term care coverage;
- * the establishment of federal standards and tax incentives for long term care insurance; and
- * a demonstration program of models for the integration of acute care and long term care.

In general, AHCA supports the thrust of each of these facets of the Health Security Act. Our members favor enhanced access to home- and community-based long term care -- but that access must be brought about for the appropriate population with the appropriate consideration for cost-effective placement. AHCA also supports measures to end the impoverishment of long term care recipients. Perhaps most relevant to this hearing, AHCA strongly supports federal standards and consumer protection for private long term care insurance -- so long as those federal standards do not raise the cost of long term care policies out of the reach of those who would otherwise benefit from coverage.

In particular, I would like to raise a number of concerns regarding the specifics of the long term care provisions of the Health Security Act.

EXPANSION OF HOME- AND COMMUNITY-BASED LONG TERM CARE

The proposed expansion of home- and community-based is probably the long term care component of the bill with the most political and popular appeal in the short run. However, it is also likely to become the long term care component that poses the most difficult fiscal and political problems in the long run.

The Health Security Act would create a new "capped entitlement" program for home- and community-based long term care. The proposed program would provide a broad array of long term care services -- regardless of age or income -- to a broadly defined disabled population. The federal government would provide most of the funding under a federal/state partnership. Federal funding would be capped based on the estimated cost of serving the disabled population. Eligibility for program benefits would be based on need for assistance with at least three out of five Activities of Daily Living (ADLs), cognitive impairment, profound mental retardation, or -- for children under the age of six -- dependence on technology and risk of institutionalization.

AHCA's concerns with these proposals are that they, in fact, may be too good to be true. We have serious doubts that the federal and state governments can provide the contemplated long term care services to this broad a disabled population at the costs currently estimated. This skepticism leads us to wonder what the consequences would be for those would-be beneficiaries who expect more than the program can afford to give them, for taxpayers, and for long term care providers. How would states hold program expenditures to their capped allotments? What would happen to disabled individuals who meet the program's functional criteria and expect long term care services that a state cannot afford to render?

Believing as we do in the need for a strong private/public partnership in long term care, the President's proposal for an ambitious new government program for home- and community-based long term care presents other concerns as well. Our members are concerned that, having heard of the President's plans for a new entitlement for long term care, most Americans will believe that there is no longer any need for them to plan for, save for, or insure against the costs of long term care. If this sounds pessimistic, consider that after more than 25 years of Medicare, a public opinion survey conducted for the Employee Benefit Research Institute by the Gallup Organization this past summer found that 45 percent of respondents believe that Medicare pays for long term care.

The proposed capped entitlement for home- and community-based long term care raises a few other concerns from the standpoint of coordination with other sources of long term care financing -- both public and private. First, states might find the coordination of disjointed long term care programs to be awkward and cumbersome. While the remaining Medicaid long term care program would require one kind of eligibility determination for the elderly and the impoverished, the new home- and community-based program would require a different eligibility determination. Second, because of the proportionately larger federal match for the new home- and community-based program, states might face temptation to de-institutionalize Medicaid beneficiaries -- even beneficiaries who would not be well or cost-effectively served in a home or community setting. Third, to the extent that a capped entitlement leaves doubt as to who or what a state will be able to cover in a given year, the new program could be quite difficult to coordinate with private long term care insurance.

In sum, regarding the President's proposals for a new capped entitlement to home- and community-based long term care services, AHCA favors an approach that makes the entire long term care continuum stronger and more accessible. The nation's frail elderly will continue to need access to nursing facility services as well as home- and community-based care. Although appropriate for many, home- and community-based long term care is not

appropriate for still many other disabled individuals for whom nursing facility care is both necessary and cost-effective. Therefore, the Administration and Congress must not strengthen one part of the long term care continuum to the detriment of another.

FEDERAL STANDARDS AND TAX INCENTIVES FOR LONG TERM CARE INSURANCE

AHCA is especially pleased that the Health Security Act includes provisions to establish minimum federal standards for long term care insurance and to clarify the federal tax treatment of private long term care insurance. Both of these steps will help to establish the value of long term care insurance in the eyes of consumers and, therefore, help private insurance to realize its potential in financing long term care.

Of some concern, however, is the Health Security Act's proposed requirement that all policies provide for nonforfeiture of benefits in the event of a policy lapse. Because of the cost that this feature adds, and our preference for flexibility and consumer choice, our Association would prefer that nonforfeiture be a required policy option. However, if nonforfeiture is to be a required feature of all private long term care insurance policies, the benefit must be designed in a way that maintains policy affordability. It is our hope that AHCA can help the Energy and Commerce Committee in this regard.

CONCLUSION

Necessity and pragmatism shows clearly that government cannot and should not try to take on the entire burden of long term care. Private sector ways and means must be harnessed in partnership with public programs and resources. In order to form the required partnership, Congress should seek to maximize the role of private long term care insurance through:

- * federal standards and consumer protections:
- * tax clarification for long term care insurance products; and
- * public education.

AHCA is pleased to see that the President's health care reform legislation includes these measures.

For the required long term care private/public partnership to succeed, the Congress must avoid:

- * over-regulation of long term care insurance;
- * disincentives to appropriate and cost-effective long term care placement;
- * expectations for government programs that those programs cannot meet;
- * overcommitment of federal and state fiscal resources; and
- * lack of clarity between public and private roles.

AHCA is committed to working with Congress and the Administration to help avoid these potential policy problems.

AHCA is pleased that the Clintons, the Congress, and the public are talking about long term care in the context of health care reform -- and we are pleased to have been invited to be a part of that conversation. Again, thank you for your attention and your consideration.

Mrs. COLLINS. Thank you very much. Mr. Firman?

STATEMENT OF JAMES P. FIRMAN

Mr. FIRMAN. Ladies and gentlemen, thank you for the opportunity to comment on those sections of the Health Security Act that address long-term care insurance, Medigap, and other forms of supplemental coverage. In my written testimony, I provide detailed comments in several sections of the bill, but let me summarize for you a few of our conclusions and recommendations.

We think that title 3, part 3 of the Health Security Act will provide an excellent and much needed framework for regulating private long-term care insurance. Much of the specific language is consistent with the recommendations we have made to this committee and others in Congress over the past several years.

We strongly support most of the key elements of the proposed legislation, including national minimum standards that will be applied to every State, assigning the Secretary of HHS, and a National Advisory Council the responsibility for developing most of the regulation, focusing on a process for developing appropriate regulations, rather than legislating details, and providing Federal funds for enforcement and consumer protection.

Despite our great enthusiasm for the general framework, we have several recommendations for specific improvements. We think it is essential that there be adequate consumer representation on the National Long-Term Care Insurance Advisory Council. This is critical to the integrity of the process and to the quality of the results.

We would also like to see a stronger link between the recommendations of the advisory council and the actions actually to be taken by the Secretary.

We urge that discretionary groups be specifically included in those sections of the legislation that address sales and marketing practices of employer groups and membership associations.

Consumer protections against post-claims underwriting should also be strengthened. Section 7 of the current NAIC Long-Term Care Model Act is considerably stronger than the proposed language and should be the basis for Federal law in this area.

We recommend that a new section be added regarding modification to private long-term care insurance benefits, to dovetail with public long-term care coverage. Given the intent to phase in public coverage for home and community-based care, some action is clearly needed to ensure that private insurance is a true complement to public coverage to prevent the possibility of windfall profits to current insurers and to remove the potential reason not to purchase private insurance.

Regarding the tax treatment of private policies, we strongly support clarification, but we urge that the Congressional Budget Offices conduct a study of the expected benefits and costs of these proposed tax expenditures. We believe this should not be an ideological question, but a dollars and cents question. Who is going to benefit and what is it going to cost?

Title 4, subtitle (a) proposes considerably fewer changes for the regulation of Medigap policies. This is largely due to the fine work of this committee in OBRA 90.

We strongly support the new requirement that all issuers have an annual open enrollment period of at least 30 days. However, we recommend additional language ensuring that Medicare beneficiaries of all ages will have a 6-month open enrollment period when they first enroll in Part B.

The Health Security Act should also address two other issues related to Medigap coverage. The NAIC should be given specific instructions to modify the 10 standardized benefits packages to reflect the expected changes in Medicare, particularly as they affect prescription drugs.

In addition, Congress still needs to make technical corrections to OBRA 90 regarding the sale of policies that duplicate existing coverage.

Regarding supplemental health benefits for members of health care alliances, we see a need to clarify that employers and associations can limit coverage to members of their group, but they must accept every member of that group who applies for coverage.

We are also very concerned about the potential proliferation of discretionary groups established specifically to obtain preferential rates on supplemental health benefits policies.

Other than these relatively few provisions, States will be free to regulate these supplemental benefits policies however they choose. The unfortunate history of Medigap insurance tells us that we should expect an inefficient and problematic marketplace characterized by low value products and questionable coverage.

Given the expected marginal nature of these products, there may not be any compelling Federal reason for greater Federal intervention at this time. However, we would like to see the National Health Board monitor developments in this area and be authorized to develop further regulations later if needed.

On the other hand, there is a clear, compelling Federal interest in cost-sharing plans. From a consumer perspective, these cost-sharing plans will be considered an integral part of their basic coverage. Therefore, we support the proposed rules for offering coverage, prohibitions on coverage for copayments established under section 1135, and requirements for loss ratios of at least 90 percent.

In conclusion, United Seniors Health Cooperative strongly supports the general thrust and most details of the Health Security Act, regarding regulation of long-term care insurance, Medigap and other forms of supplemental coverage. We urge Congress to carefully consider the changes we have proposed to strengthen the legislation. We are prepared to work with Members of Congress in any ways we can to ensure the best possible result.

Thank you.

[The prepared statement of Mr. Firman follows:]



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TESTIMONY OF JAMES P. FIRMAN
PRESIDENT OF THE UNITED SENIORS HEALTH COOPERATIVE
BEFORE THE
SUBCOMMITTEE ON COMMERCE, CONSUMER PROTECTION AND COMPETITIVENESS
AND THE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
OF THE
ENERGY AND COMMERCE COMMITTEE
OF THE
U.S. HOUSE OF REPRESENTATIVES

NOVEMBER 9, 1993

Ladies and gentlemen, my name is James Firman. I am President of the United Seniors Health Cooperative. Thank you for the opportunity to comment on the sections of the Health Security Act that address long-term care insurance, Medigap insurance and other types of supplemental health insurance.

United Seniors Health Cooperative (USHC) is a non-profit consumer organization that helps people to be informed consumers of health care and health insurance. USHC does not sell, endorse or receive any money from the sale of insurance products. Each year, USHC staff and volunteers counsel and educate several thousand consumers about Medigap, long-term care insurance and other types of supplemental insurance. We have written several books for consumers and professionals on health insurance. USHC has conducted several Foundation-sponsored research studies on various aspects of Medigap and long-term care insurance. For the past four years, we have worked closely with the NAIC to implement the Medigap provisions of OBRA 1990 and to develop better model laws and regulations for private long-term care insurance.

Because I have had only a few days to examine the actual legislation, please consider my remarks and recommendations about various sections of the Health Security Act to be somewhat preliminary.

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Long-Term Care Insurance

The Health Security Act proposes major and much needed changes in the regulation of private long-term care insurance. Title II, Part 3 addresses regulation of private long-term care insurance and Title VII, Subtitle G addresses tax treatment of long-term care insurance premiums and benefits.

In our opinion, Title II, Part 3 provides an excellent general framework for regulation of private long-term care insurance. These changes are consistent with recommendations USHC has made to this Committee and others in Congress over the past several years. Specifically, the bill contains several key elements, which we strongly support, including:

1. Enacting national minimum standards which are to be applied in every state. This approach has led to dramatic improvements in the Medigap market and is even more sorely needed for long-term care insurance.
2. Assigning to the Secretary of HHS the responsibility for developing most of the specific regulations with the help of a National Advisory Council. Given the very ambitious task of developing comprehensive regulations, we strongly support assigning the responsibility to a federal agency with sufficient advisors, professional staff and financial resources to do the job right.
3. Establishing a good process for developing appropriate regulations, rather than specifying the details of regulations in the legislation. Given the complexity of many specific regulatory issues to be addressed and the need for more analysis, we believe the bill appropriately avoids the temptation to legislate details in most areas.
4. Recognizing and providing funding for both enforcement and consumer education regarding long-term insurance. Both of these areas are critical to improving the marketplace for private long-term care insurance.

Despite our great enthusiasm for most of Title II, Part 3, we recommend consideration of specific improvements to several sections. The comments that follow are limited to those sections which we think need to be changed or clarified.

Section 2301 requires that states comply with several sections of the current NAIC Model Act and Regulations until the time that new federal standards are developed and become effective. We support all of the specific requirements. However, we strongly urge that section 2301(2)(h) which concerns sales through employers or membership organizations be expanded to include discretionary groups. Discretionary groups have been the source of the most

egregious abuses in the group market: To exclude them from this section would vitiate the intent and effectiveness of the entire section.

Section 2302 establishes a National Long Term Care Insurance Advisory Council. Section 2302(b)(1) states the Council shall consist of five members, each of whom has substantial expertise in matters relating to the provision and regulation of long-term care insurance. We strongly urge that one or more of these seats be designated for persons with suitable expertise who represent consumer interests and perspectives. Adequate consumer representation is essential to the integrity of the process as well as the quality of the final results.

Section 2302(i) describes activities of the Advisory Council. We recommend that this language be strengthened to require the Council to consult with consumers, industry representatives, service providers and other interested parties.

Sections 2321 discusses many specific areas for which the Secretary will develop federal standards and requirements. We agree about the need for and appropriateness of virtually every aspect of this section. However, section 2321(e)(2), which requires companies to provide comparisons of their policies to policies offered by other private insurers, is neither appropriate nor feasible. It is unreasonable to ask a company to provide an unbiased comparison of its product with those of competitors. We believe that the approach used in Section 4012(f)(1) regarding information on Medigap insurance would be a better way to achieve the same objective.

Section 2324 addresses many important requirements related to sales practices. It is very important that Section 2324(g) regarding sales through employers or membership organizations be expanded to include discretionary groups. Without this change, we will have a good law that applies only to those groups that least need to be regulated.

Section 2325(c) addresses the rights of insurers to cancel or deny benefits based on fraud or non-disclosure. This section limits the ability of insurers to practice post-claims underwriting. The provisions in the proposed legislation are considerably weaker than the prohibitions against post-claims underwriting that are already in Section 7 of the NAIC Long Term Care Model Act. We recommend that the current NAIC language be used as the basis for federal law in this area.

Section 2361 authorizes grants for consumer education to states, alliances and national organizations. This effort could have a very beneficial effort on the long-term care market. However, we have serious concerns about Section 2361(a)(3) which authorizes grants to national organizations representing insurance consumers,

long-term care providers and insurers. This provision is fraught with potential conflicts of interests. It is unrealistic to expect that organizations that have a vested financial interest in the sale of private long-term care insurance will be able to provide objective, unbiased information and counseling to prospective purchasers. This section needs a clear prohibition against grants to organizations where there may be such conflicts of interests.

Title II, Part 3 fails to address an important issue: Modifications of private long-term care insurance benefits to dovetail with public long-term care coverage. Most long-term care policies currently in force and on the market today specifically say that they will not pay for any service covered by a government program. Other policies are silent on the issue. Only a few companies (for example Metropolitan Life) have specific language in their policies that says that if government benefits for long-term care change, the company will make appropriate modifications in the private coverage.

The Health Security Act clearly intends to phase in public coverage for home and community-based long-term care that will not be subject to a means test. Some action is needed for at least three reasons: 1) to ensure that private insurance becomes a true complement to public coverage, 2) to prevent the possibility of windfall profits to current insurers, and 3) to remove a potential reason not to purchase private insurance. Our recommendations are as follows:

1. New policies being offered for sale should have explicit language stating that as government benefits for long-term care change, the company will make appropriate modifications in the private coverage as specified by the Secretary. These changes should be cost-neutral for both consumers and insurers.
2. Long term care insurance policies currently in force that provide home and community care benefits should also be required to amend their coverage in cost-neutral ways to ensure that the introduction of new public benefits doesn't result in a de facto devaluation of private insurance. If insurers do not make this change, they should not be allowed to deny benefits because of services paid for by the new public program.

Subtitle G of Title VII addresses the tax treatment of long-term care insurance policies and accelerated death benefits under life insurance contracts. We agree with the need for clarification of the tax consequences of long-term care insurance. We agree that benefits paid to meet long-term care needs should be tax-exempt.

However, we urge more study on the question of whether the federal government should provide tax incentives for people to purchase private long-term care insurance. We suggest that the Committee ask the Congressional Budget Office for an analysis of the benefits

and costs of this proposed tax expenditure. This analysis should include estimations and projections of:

- a) the likely costs to the federal government of the proposed tax subsidies
- b) how many consumers in various income categories would benefit from these tax breaks.
- c) the likely impact on the overall market penetration of long-term care insurance.
- d) the potential savings to the Medicaid program because of more people having private long-term care insurance.

In our view, this issue should be considered on a cost/benefit rather than an ideological basis. Tax subsidies may or may not be the most efficient way to encourage more consumers to purchase private long-term care insurance. For example, programs such as the Robert Wood Johnson Public/Private Partnerships may be a less expensive alternative. Direct subsidies for moderate-income individuals might also be more cost-effective.

Medigap Insurance

The Health Security Act (Title IV, Subtitle A) proposes relatively few changes for Medicare supplemental policies.

Section 4011 requires all issuers of Medigap policies to have an open enrollment period (which may be specified by the Secretary) of at least thirty days each year. This is an important market reform that is consistent with the rules which are proposed for other types of health insurance. However, we believe that there are two issues regarding open enrollment that should be clarified:

1. When beneficiaries first enroll in Medicare Part B, they should still be entitled to a six-month open enrollment period.
2. Both the annual open enrollment period and the initial six-month open enrollment period should apply to Medicare beneficiaries of all ages, not just those over the age of 65.

Section 4012 instructs the Secretary of HHS to develop and distribute comparative materials about all Medicare supplemental policies issued in a state and to assess each insurance company for a pro rata share of the costs. This language should be clarified to allow HHS to provide contracts or grants to the states to carry out these provisions.

We recommend that two other issues regarding Medigap insurance be addressed by the Health Security Act:

1. The NAIC should be given specific instructions to modify the ten standardized benefit packages to reflect the expected changes in Medicare coverage. Clearly, Plans H, I and J must be changed due to the new prescription drug benefit. Proposed changes in co-payments for other services (such as home health care) may also require modifications in regulations for Medigap coverage.

2. Congress still needs to make technical corrections to OBRA 1990 regarding the sale of policies that duplicate existing coverage. The Health Security Act should address this problem in case the technical corrections are not included in other legislation.

Overall, there is relatively little reform needed in the area of Medigap insurance. This is largely due to the fine work of this Committee and other members of Congress in passing the Medigap reform legislation included in OBRA 1990.

Supplemental Insurance

The Health Security Act (Title I, Subtitle E, Part 2) proposes different approaches to regulating supplemental health insurance for consumers who purchase their primary insurance through the health alliances. The Act addresses two types of policies: supplemental health benefits policies and cost sharing policies.

Supplemental health benefit policies provide: a) coverage for services and items not covered in the comprehensive benefit package, b) coverage for services and items in the package for which there are limits on amount, duration or scope, or c) both. Section 1422 sets some standards for these policies. Section 1442 (b)(1) requires insurers to accept for enrollment every individual who applies. Section 1442(b)(2), which provides exceptions for certain offerors needs should more clearly state that although employers and associations can limit coverage to members of their group, they must accept for enrollment every member of the group who seeks such enrollment. We don't think this exception should apply to discretionary groups which are established primarily for buying and selling insurance. We are concerned about a potential proliferation of discretionary groups established specifically to obtain preferential rates on supplemental health benefit policies. We believe this would be contrary to the spirit and intent of this section.

We support the other provisions of Section 1442 regarding prohibitions on the sale of duplicate coverage, restrictions on certain marketing abuses, and the availability of civil monetary penalties.

Other than these relatively few provisions, states will be given a free hand to regulate these policies however they choose. The result is likely to be a rather inefficient and problematic marketplace with many low-value products that offer questionable coverage. The early history of Medigap insurance is likely to repeat itself with these policies. Congress should consider, given the expected marginal significance of these policies, whether there is any compelling reason for greater federal intervention.

Unlike the supplemental benefit policies, there is a compelling federal interest in the cost-sharing plans. From a consumer perspective, these cost-sharing plans will be viewed as an integral part of their basic coverage. Therefore it is appropriate that the legislation (Section 1423) specifies rules for offering coverage, prohibits coverage for co-payments established under section 1135, and requires loss ratios of at least 90%. We support these provisions. However, I would recommend that Congress seek clarification on the respective roles of the alliances and the state insurance departments in approving the cost-sharing plans and in enforcing the specified standards.

Conclusions

United Seniors Health Cooperative strongly supports the general thrust and most of the specific details of the Health Security Act regarding regulation of long-term care, Medigap, and other forms of supplemental health insurance. We urge Congress to carefully consider the changes we have proposed to strengthen the legislation.

The Board of Directors and members of USHC believe Congress has a historic opportunity to pass legislation that will greatly improve health insurance for all Americans. We are prepared to work with members of Congress in any ways we can to ensure the best possible result.

Mrs. COLLINS. Thank you.

Mr. Firman, although the bill calls for the Secretary to promulgate regulations on a range of topics, it is possible that the regulations could provide even a lesser degree of consumer protection than currently exists in the NAIC model, which will become effective until such regulations are in place. Now, would you support a provision that the regulations could not be less stringent than those in NAIC?

Mr. FIRMAN. I would support—yes, I would support that. Plus, I would also support language to strengthen the link between the recommendations of the Advisory Committee and what the Secretary actually does. Right now, the bill says that the Advisory Council makes recommendations, but it does not specify that the Secretary necessarily has to pay attention to them. I think there should be a stronger link in that area.

Mrs. COLLINS. Mr. Nadel, you state in your written testimony that long-term care insurance is not an appropriate product for all people to purchase. Do you think the bill should require that financial guidelines be presented to and discussed with potential purchasers to help them determine whether long-term care insurance is appropriate for them?

Mr. NADEL. Yes. We think that the important thing is that consumers be given information about the appropriateness and particularly that people who either are on Medicaid or are very likely to be on Medicaid, due to low-income, be advised that this may not be an appropriate purchase. This is not to say that we are advocating continued Medicaid financing for long-term care. As long as we are in the system we are in, people should be fully advised of their options.

Mrs. COLLINS. Well, it seems that, at this point, long-term care insurance is only appropriate or could be conceived as being only appropriate for people who have enough money or enough assets to make it worth their while to spend money to protect those particular assets. So, I guess the question should also be, should the bill require that some kind of uniform financial guidelines be prepared or presented?

Mr. NADEL. Well, I do not know if we would go as far as to say there should be specific guidelines, because different people may be in different circumstances. It could well be, for example, that people of low-income have relatives or children who would not wish to see their parents relying on Medicaid. They may be willing to put forth the premiums. People have different reasons.

So, while we do advocate that there be information given and that it be required that information be given about the appropriateness, I am not sure we would go as far as saying you should not buy this if your income is below X dollars. On the other hand, there probably should be uniformity in the kind of advice that is given, but we would not necessarily put a dollar limit and say below such and such an income you should not have this.

Mrs. COLLINS. One of you mentioned the T word, which is tax. I could not help but wonder that, with the understanding that long-term care insurance is geared toward the needs of the more wealthy Americans, would a tax benefit for the purchase of long-

term care insurance be likely to benefit anyone who does not have substantial financial assets? Either of you. Mr. Nadel? Mr. Firman?

Mr. FIRMAN. Well, I agree with your question. I have not seen any analysis of what these tax expenditure are going to cost, what would the likely cost be to the Federal Government, how many consumers, in various categories would benefit, what effect would it have on the number of people who purchase insurance, and would it have any potential savings to the Medicaid program? I think those are very serious questions. We are in an era of budget constraints. What will it cost and who will benefit are questions that I have not heard any answers to.

Mrs. COLLINS. Ms. Bern, in your written testimony, in opposition to mandatory nonforfeiture benefits, you stated: "Since most consumers who let their policies lapse do so in the first 2 years of coverage, there would be no value, only cost in requiring nonforfeiture benefits." Would you agree, however, that, if a consumer paid premiums for say 10 years, then there should be some kind of nonforfeiture benefit?

Ms. BERN. I certainly think nonforfeiture benefits should be available to anyone who purchases long-term care insurance. My objection is to forcing someone to buy non-forfeiture benefits, even if it is an informed choice. Many people would rather buy a richer home health or nursing home benefit and use their money that way, instead of buying the nonforfeiture protection. I think, as long as it is an informed choice, they should have that choice.

Mrs. COLLINS. So, you do not agree in the mandatory business of nonforfeiture?

Ms. BERN. I do not agree that it should be mandatory.

Mrs. COLLINS. Mr. Willging, you do not either, right?

Mr. WILLGING. No. I would agree with Ms. Bern. It should be an option. There should be clear information available, but it should be a benefit which is up to the individual as to whether he or she wishes to purchase or not purchase that benefit.

Mrs. COLLINS. Mr. Firman?

Mr. FIRMAN. We strongly support mandatory nonforfeiture. I would like to point out that the National Association of Insurance Commissioners, after 3 years of deliberation, has also taken the position that there should be mandatory nonforfeiture in all long-term care insurance policies.

Mrs. COLLINS. Ms. Spencer, do you have a thought on this?

Ms. SPENCER. That really was not within the context of what I am prepared to speak on today. However, in our long-term care, we do find that many people do opt out of the nonforfeiture benefits. So, I think we would favor a choice.

Mrs. COLLINS. I am not going to leave you out, Mr. Nadel.

Mr. NADEL. I was afraid of that. We support the NAIC, which presents a consensus opinion of insurance commissioners around the country that these benefits be mandatory.

Mrs. COLLINS. Thank you. Mr. Waxman.

Mr. WAXMAN. Thank you very much.

Let me begin with a question for the entire panel. In reading your testimony, I have come away with a sense that you agree—all of you agree—that it would be appropriate and timely for the Federal Government to set standards and guidelines for the sale

and marketing of private long-term care policies. Now, there may be some disagreements among you as to the actual content of those standards, but, for the record, are you all in agreement that the time has come for the Federal Government to act in this area?

Mr. FIRMAN. Yes.

Mr. WILLGING. Yes.

Ms. SPENCER. Yes.

Ms. BERN. Yes.

Mr. NADEL. Yes.

Mr. WILLGING. It will never happen again.

Mr. WAXMAN. I ought to quit while I am ahead.

Let me go on this nonforfeiture issue. Ms. Bern, let me ask you about it. As you know, nonforfeiture benefits are designed to provide protection for consumers who have purchased long-term care policies in the event such a policy lapses. These benefits, in essence, provide a return on the investment the policyholders made through the premiums he or she paid to the insurance company over time.

As you have noted, the Clinton proposal has tried to address this problem. The plan requires the Secretary to develop regulations that establish appropriate nonforfeiture benefits for long-term care policies that lapse for any reason, other than death, after remaining in effect for a specified period of time. This approach is similar to the one taken by a number of us in the long-term care proposal we introduced in the last Congress.

Both your company and your association object to this approach, on the grounds that these provisions would result in higher premium costs associated with the provision of a nonforfeiture benefit. I appreciate that concern and want to understand better why, given both your numbers and those of GAO, this protection should not be built into the basic policy at a relatively low price?

Ms. BERN. The cost of a nonforfeiture benefit is much higher for younger people than it is for older people because there is a much longer period over which that protection occurs. Therefore, if a younger person, say a 45-year-old is buying a policy with a \$200 premium, the cost of the nonforfeiture benefit would be a sizable portion of that premium. That is a large increment if that person really does not want that coverage. What I am proposing is that everyone should have to be offered a nonforfeiture benefit and perhaps even sign a consent form saying that they knowingly turn down the offer. But, I would propose that someone who knows what they are turning down should not have to buy it if they prefer to use their money on another benefit option.

Mr. WAXMAN. Well, let's look at the GAO's testimony which states that about 20 percent of long-term care policies lapse during the first year of ownership and that about half of all such policies lapse within 5 years. HIAA data seem to indicate that 50 percent of lapses are due to reasons other than deaths or replacement policies—reasons such as cancellation or non-payment of premiums. It seems to me that under either analysis, without some sort of nonforfeiture benefit, a lot of consumers are just going to lose out.

Given these significant numbers and, as far as I know, no expectation that these figures will diminish, shouldn't the basic long-term care policy protect against the real possibility that when a

policy lapses no benefits will be paid, even though premiums have been paid for many years?

Ms. BERN. It is our experience at John Hancock and, I believe, according to an industry survey, that those lapse numbers are not borne out by the data. Our lapse experience is between 7 and 8 percent, and that is not an unusually high lapse rate. Many people simply will keep their policies. They will go into benefits or they will die. Relatively few people will ever use the lapse protection. Those people who buy it and use it will of course be glad that they bought it; but those people who had to buy it and did not want it will not be so happy.

Mr. WAXMAN. Well, it seems that, if the numbers are as high as both GAO and HIAA are saying they are, one, there is some predictability to this problem, and, two, the costs of protecting against it could be spread among policyholders at a relatively low cost. You might also just take note that the National Association of Insurance Commissioners approved standards that require nonforfeiture benefits for all long-term care policies. I obviously find that we disagree, but I did want to point those issues out. Thank you.

Ms. BERN. Thank you.

Mrs. COLLINS. Mr. Stearns?

Mr. STEARNS. Thank you, Madam Chairwoman.

Mr. Firman, I appreciate your comment, what will it cost and who will it benefit? We are all concerned with that, and not just with long-term care, but with the whole program.

Mr. Willging, my question to you is your written testimony refers to the proposed Home and Community Long-Term Care Program as "capped entitlement." The Health Security Act explicitly states that nothing in the Act "shall be construed to create an entitlement in individuals." Could you please elaborate on your remarks?

Mr. WILLGING. Well, at the risk of being profane, I would like to quote a statement that I think originated in the Congress. "If it walks like a duck, if it talks like a duck, if it looks like a duck, it may very well be a duck." The words are not as I think important as in fact the eligibility criteria within that home and community-based care program. Essentially, there are no financial or age requirements in terms of eligibility. Furthermore, it has been grossly underfunded in terms of the projections. I mean, \$65 billion over 5 years does not come close to dealing with the needs of even the severely disabled.

I think the problem is going to be the political pressures which will come about when Aunt Nellie, on August 13th, 1998 walks into her local eligibility office and says I now want this program for which I am both functionally entitled, as well as entitled in terms of age, and these social services intake manager says I am sorry, we ran out of our money 2 days ago. I think the political pressures to finally make that non-entitlement a true entitlement will be unwithstandable.

Mr. STEARNS. OK. So, I think you are sticking by, as I understand your comment, by entitlement.

This is perhaps for all of the folks on the panel. Can you articulate the difference—I have heard this term so often used, I am a little confused between public and private responsibilities for long-term care under President Clinton's proposal. How would Govern-

ment and insurers coordinate the public and private sector coverage under this new program? Would Medicaid persons currently receiving services like those outlined be absorbed under the President's bill?

Why don't we start with Kathelen. I cannot read your last name.

Ms. SPENCER. I am sorry, Congressman. I do not have the answer to that question.

Mr. STEARNS. Oh, that is great. I respect you. Ms. Bern?

Ms. BERN. I think it would be very difficult to coordinate the public and private pieces of this, because each State would have a different policy, a different—

Mr. STEARNS. I do not mean to be rude. Can you tell me the difference between public and private? Can you articulate what the difference is?

Ms. BERN. I understand the private term to refer to benefits that are a result of a private long-term care insurance policy; whereas, a public program would be provided through the Health Security Act, or other Government program. That is how I am referring to it.

Mr. STEARNS. That is my main question. I do not mean to interrupt you. Is there someone on the panel who would like to also? Mr. Firman?

Mr. FIRMAN. Well, as I understand it, essentially Medicaid, for nursing home coverage, would stay essentially the same as it is now. In addition, there would be a new public program to provide home and community-based care for people who meet the eligibility criteria.

I disagree with Mr. Willging. It clearly is not an entitlement—and individual entitlement. States will have a budget and they will do the best they can within that budget. There is no promise of any specific service package. The private insurance would therefore dovetail with that.

You are raising what I consider to be a very important point that is not in this bill. There is no discussion about how private long-term care insurance will coordinate with the public benefits. If you read most policies now, they specifically say we will not pay for a service if it is paid for by the Government. Other policies are silent on this issue and only a few, such as the policy offered by Met Life, says that, if Government benefits change, we will change our coverage. We think this needs to be changed so that, clearly, consumers will not be concerned about creating windfall profits or having their private benefits vitiated. There is a need for a coordination of benefits clause in the new private insurance.

Mr. STEARNS. Mr. Willging.

Mr. WILLGING. I have got a simplistic definition. When I pay for the services I am receiving it is private. When you pay for my services, it is public.

Mr. STEARNS. OK.

Mr. WILLGING. The question is when should your tax dollars be utilized to pay for the services I need? I think there is a critical role for public funding for those who cannot afford to care for themselves. By the way, on President's Home and Community-Based Care Program, I strongly support that provision, with one exception. I support the expansion of alternatives across the continuum

law of long-term care. My only problem is essentially there is no financial criteria for eligibility. That makes it your responsibility to pay for my services, no matter whether I could afford to pay for them myself or not.

Mr. NADEL. Well, I agree with the distinction drawn between public and private. I would say that we would support a robust private market. We think that market would become more robust with the adoption of the kind of consumer protection measures contemplated in the bill, so that people would have confidence in the product and know what they are buying.

Mr. STEARNS. My time has expired. Thank you, Madam Chairwoman.

Mrs. COLLINS. Mr. Wyden.

Mr. WYDEN. Thank you, Madam Chairwoman.

I think listening to all of you, it sounds like we are making some headway in terms of trying to set out some standards that would really meaningfully protect the consumer. I am, at this point, I guess more concerned about enforcement than anything else, because the history of enforcement is, at best, we have seen a sad sack State enforcement effort, if you look nationally.

Why don't we start with this matter of inflation protection, Mr. Nadel. Let me ask you how you would envisage enforcement working there? Now, you are talking about how senior citizens would get inflation protection, unless they sign their rights away. Now, I can see agents just—particularly, given what we saw when we sent the senior citizens undercover—just telling senior citizens to sign it away automatically, and then people have all of their benefits eaten up by inflation.

Now, what is in the legislation, in terms of trying to raise enforcement standards where we have a problem based on the reports that you all have been issuing for the better part of a decade now?

Mr. NADEL. Well, the inflation protection in the administration's bill is pretty much the same as in the NAIC Model Act. That is, it is a mandatory offer of inflation protection, and not a mandatory feature of the premium.

In terms of enforcement, there is no specific enforcement mechanism in that provision. Rather, there are a series of enforcement mechanisms at the end of the section on long-term care, which vests enforcement in the States which, as you know, have been variably successful. There is a fairly draconian provision in the bill. I do not use draconian in a negative sense. I think it is a rather large club which simply says to the industry you cannot sell this product in a State that does not meet the enforcement provisions of the law. This, of course, is a rather ingenious device to give the industry a rather substantial incentive to make sure that the Insurance Commissions in the States are doing their jobs. It is rather clever I should think.

Mr. WYDEN. What about the idea of trying to have some senior citizens involved in the various Insurance Departments testing, sort of like we did when we were out looking at the long-term care area? I mean, we were just stunned by the level of misrepresentation here as recently as a couple of years ago. I mean the industry comes to these hearings constantly and says everything is getting better, we are cleaning up our act, we are doing a better job. We

went out and got on tape some of the most flagrant, outlandish misrepresentations imaginable. I still have great reservations about what is going to happen in the enforcement area. What would you think of the idea of adding to this in the State Insurance Departments and people who would do some testing?

Mr. NADEL. I think that anything that the Insurance Departments do to test what is in the market, very similar to the kind of civil rights enforcement testing that goes on in the housing market, would be appropriate, consistent with proper protection of everyone's civil liberties. So, that seems like an idea that would have merit. I would not think it ought to be written into the law. In terms of a strategy for a State Insurance Department, it would seem like a pretty good idea.

Mr. WYDEN. A question for you, Ms. Bern, and Ms. Spencer. I have great reservations about dread disease policies which are still going to be allowed under this legislation. In my view, it does not make anymore sense for a consumer to be health insurance disease by disease than it would to purchase fire insurance for your house room by room. We have seen again Mr. Nadel just churning out reports talking about how these dread disease policies are not of much value. Would you all support, as representatives of the industry, at least setting out some Federal standards for dread disease coverage so we could make sure that what you all have said you have wanted—that people do get some value out of these policies—that that actually happened?

Ms. BERN. I will defer to Ms. Spencer. We do not sell dread disease.

Ms. SPENCER. OK. Yes. We would be supportive of that. I would like to say too that a conundrum that we have found in another area is that when the Federal body is mandating standards and the States are charged with approving rates, sometimes there is a problem because you run into issues of the States being charged with solvency and consumer protections, though we would promote one body having the whole picture. Certainly, we would agree. We would support companies continuing to have the flexibility to make innovations in benefits. Ours is a consumer-driven market, and we do like to be able to introduce new things. Certainly, we would agree with some basic standards.

Mr. WYDEN. Madam Chairwoman, my time is up. If we could have the HIAA furnish to you and to Chairman Waxman what they would be willing to accept in terms of Federal standards on dread disease policies, I think that would be something that would help us move along on this.

Mrs. COLLINS. That is a request that we will make. Thank you very much.

Mr. WYDEN. Thank you.

Mrs. COLLINS. Without objection.

Mr. Greenwood.

Mr. GREENWOOD. Thank you, Madam Chairwoman.

I would like to hear from each of you as to whether you believe that, in some way, this long-term care should be a means tested. If you think it should be means tested, where should we draw that line?

Mr. NADEL. Mr. Greenwood, our work really was concerning just the private components. We would have no position on the extent to which it should be means tested.

Mr. GREENWOOD. You can get away with that.

Ms. BERN. We feel very firmly that people should be encouraged to take care of their own long-term care needs, if they can afford private, long-term care insurance. One of the reasons is very practical. There is simply not enough money to go around. The long-term care cost is exorbitant. It is growing every day. If we do not find some way of bringing the public and private parts together, there will simply never be enough money. So, we would encourage a means test whereby people who could afford insurance would not get direct benefits.

Mr. GREENWOOD. OK.

Ms. SPENCER. I would agree with Ms. Bern.

Mr. WILLGING. Absolutely. As I suggested, Mr. Greenwood, I think the provisions for home and community-based care in the President's bill are overdue. We need to emphasize and redress, if you will the imbalance which has always existed, in favor of institutional care through public funding. When you talk about \$65 billion, which is the current price tag, divided by the 3 million severely disabled Americans, Mr. Josh Weiner suggested to the Ways and Means Committee last Tuesday would be covered, we are talking about \$5,000 per individual. There is no one in my field who thinks that you can care for a severely disabled American for \$5,000 per year. Clearly, the concept of the public/private partnership is applicable to this home and community-based program, as it is across the board in long-term care, which allows us to use scarce Federal resources for those who in fact do not have the wherewithal to pay their own way and allows the private sector, where people do have the resources, to bear their part of the burden. So, we do believe it should be means tested.

Mr. FIRMAN. We strongly believe that the home and community care benefit should not be means tested. We think it is wrong to tell people that they have to be impoverished before they can receive any assistance. I will note that the President's plan does call for cost sharing on the benefits. We think that that is a much more progressive way. We would not like to see another program for poor people which turns into a poor program. We think that people of all incomes need assistance to stay at home and that there is a compelling Federal interest in helping people to remain independent and in their own homes.

Mr. GREENWOOD. If you do not believe that people should be impoverished, is there some higher threshold—twice the poverty level, three times the poverty level, four times the poverty level—at which point you think they should handle this on their own?

Mr. FIRMAN. Well, we think that the President's plan does provide for cost sharing. It does provide for accounting for informal supports and does give the States the flexibility to provide individuals with the assistance that they need to stay at home and to provide flexible a benefits package. We think it is a good start and agree with Mr. Willging. It is not the entire package; but, we need to take a serious start and focus on home and community care. The requirement that people not be impoverished to receive benefits is

critical. If we put those types of standards up there, we will have many people entering nursing homes because they cannot get community care, spending down on to Medicaid and then costing the Government a lot more money.

Mr. GREENWOOD. Let's talk about inducements to encourage people to cover themselves. Could any of you who would like to speak address the issue of what it would take in terms of tax clarification to bring people into this market?

Ms. BERN. I think an important element here is the growing corporate group market. That is really the area of greatest growth in long-term care today—large corporations and small corporations offering their employees the opportunity to buy long-term care coverage at group rates. Tax clarification may encourage some employers to contribute part of the premium, if it is tax-deductible and, thereby, many more people would be encouraged to sign-up for long-term care insurance, if that were the case. I think it would be a substantial stimulus. The growth of the private market clearly would help the States and the Government care for those who are not buying long-term care insurance.

Mr. FIRMAN. It always surprises me that the industry, which is so concerned about standards, about raising costs and contributing to the debt are silent on the issue of what this will cost. Clearly, the insurance industry will benefit. Clearly, wealthy Americans who perhaps are going to purchase policies otherwise will benefit, but I would still call for some analysis of what will it cost the Treasury, who will benefit, and what result. There are no numbers. Until you have numbers, I am not sure how any of us can make a reasonable assessment about the efficacy of tax expenditure for private, long-term care insurance.

Mrs. COLLINS. Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Madam Chairwoman.

It is a good panel, Madam Chairwoman. I certainly have learned a lot. I just hope that we are all listening.

Ms. SPENCER, I do not think it would be out of line for me to congratulate AFLAC through you for having been designated as the safest insurance company in America by Financial World Magazine—

Ms. SPENCER. Thank you.

Mr. BILIRAKIS [continuing]. And their A-plus rating. I am not meaning to belittle Hancock when I say that. I would ask you, do you sell basic health insurance?

Ms. SPENCER. No. All of our—

Mr. BILIRAKIS. All supplemental?

Ms. SPENCER. All are designed to supplement basic coverage of one time or another.

Mr. BILIRAKIS. Does anyone who sells basic health insurance give those same guaranteed renewable for life, fully portable, et cetera?

Ms. SPENCER. That is a portion of the industry I am not real familiar with, so I do not know the answer to that.

Mr. BILIRAKIS. Does anyone know? Does anyone do that? The Federal Government—I do not know what we are going to come up with; but, one of the things that I am sure is going to be included, is portability of insurance. Are insurance companies just sitting back there and waiting for the Federal Government to mandate it,

to shove it down their throats? Is that basically what our world is like?

Mr. FIRMAN. Mr. Bilirakis, I would point out that both Medigap and long-term care insurance as sold now are currently guaranteed renewable.

Mr. BILIRAKIS. Yes. I know that. I am talking about the basic health insurance now. Do you know of any insurance companies that have guaranteed renewable for life, fully portable, et cetera? No?

Mr. FIRMAN. No. I do not know of many companies who do not do medical underwriting either. I think the point of this is to create a level playing field. What I have heard from the industry many times is, as long as the rules are changed for everybody, they can live with them.

Mr. BILIRAKIS. Yes. I realize that the subject today is long-term care, and so we are talking about supplemental and all of that. I guess I have to wonder about the other two for basic insurance.

Ms. Bern and Mr. Firman, I refer you to section 2303 of the proposed act, which allows States to apply standards that exceed minimum Federal standards. Ms. Bern, you say that you believe that separate State requirements would limit consumers' access to a wide range of long-term care insurance products by stifling competition in the market, then you say the increase in administrative costs resulting from multiple filings and approvals of the same market increase premium costs needlessly. So, you would say that there should not be separate State requirements. The Federal Government should establish requirements and you are really not even calling them minimum requirements, are you? We are calling them mandatory—what is the word—uniform requirements; is that right?

Ms. BERN. Yes.

Mr. BILIRAKIS. Would you agree with that, sir?

Mr. FIRMAN. Believe it or not, I am somewhat sympathetic to the industry's point of view on this. However, it is hard to form an opinion on the specifics for the long-term care insurance without knowing what regulations are going to come out. If the Advisory Council were given enough authority to put together strong regulations that adequately protected consumers, I might be persuaded that that would be sufficient. On the other hand, it is not clear how—what the specifics of many of those regulations would be. If it is a very weak set of regulations, I would support State leeway to pass stricter standards.

Mr. BILIRAKIS. You believe that we quite often have to make important decisions, yes or no, having less information than you have now?

Mr. FIRMAN. I sympathize with you.

Mr. BILIRAKIS. You basically would agree that, if these regulations are consumer-protective, that the uniformity of them all would be a good idea?

Mr. FIRMAN. Yes. I think the Medigap legislation is a good example. In that case, through the actual writing of the legislation, there were many strong consumer protection measures in there. By and large, I think those have proven to be adequate and, at the same time, providing some standardization for the industry, in

terms of reducing regulatory barriers. It all depends on how strong or weak the regulations turn out to be.

Mr. BILIRAKIS. Certainly.

Mr. Willging, would you agree that there should be uniformity?

Mr. WILLGING. Yes.

Mr. BILIRAKIS. OK. Ms. Spencer, do you have an opinion in that regard?

Ms. SPENCER. Yes.

Mr. BILIRAKIS. Mr. Nadel, you do? I am sorry, Ms. Spencer. I did not mean to cut you off. You are shaking your head yes.

Mr. NADEL. Yes. I think that there is some advantage to uniformity. In some ways it may even reduce costs. Also, the whole issue about what is more stringent and what is less stringent—rather than trying to decide that on a case-by-case basis may argue for uniformity.

Finally, it should be noted that the abuses in the Medigap market were not cleaned up until the Federal Government imposed standards, even though some of them were based on State standards, but not universally applied or enforced.

Mr. BILIRAKIS. My time is up. Thank you, Madam Chairwoman.

Mrs. COLLINS. Mr. Brown.

Mr. BROWN. Thank you, Madam Chairwoman.

Given that less than 5 percent of the elderly actually end up needing nursing home care and incurring enormous long-term care bills, doesn't it make sense to look at something different? Presently, people often buy long-term insurance too late in life, too often, do not really build in inflation that they need to look to, will occasionally miss premium payments, will occasionally get canceled, all of the problems presently under the President's plan. Republicans say that it is too much of an entitlement, that we will need, at some point, to vote more money to deal with that.

Why not—doesn't it make more sense to establish a large risk pool, such as the entire U.S. population in a single-payer kind of way, and charge a small premium from the beginning to provide coverage to those few Americans unlucky enough to have to use it late in life? What is wrong with that?

Mr. WILLGING. Well, I think it is precisely the fact that very few Americans are going to require extended long-term care is what makes it such an insurable event in people's lives. That is the whole concept underlying insurance. If all of our houses were likely to burn down tomorrow, I suspect that it would be very difficult to find homeowners' insurance.

Quite frankly, I think the problem is, in terms of gross numbers, if you start in fact developing a social insurance program, a universal entitlement program, we are talking about massive amounts of new Federal or at least public funding which currently are not required because we have such a heavy involvement of the public sector or the private sector.

Right now, 45 to 50 percent of funds going into long-term care, or at least into the nursing home side of long-term care are public funds; but that means 50 percent are private funds. Suddenly, by having a universal entitlement program, you move all of those private funds, \$30 to \$40 billion, onto the public books, and we start

talking about massive resources which currently the American Public is not required to shoulder.

Ms. BERN. Although the statistic you cited is relevant to people who are in a nursing home for a long period of time, there is other data to indicate that 43 percent of Americans will need long-term care at some point in their lives. So, it is not such an isolated event. Again, the numbers are also very large. Right now we spend about \$60 billion a year just on nursing home expenditures. About half of that is public money; but, again, more than \$30 million is private. That does not even count for the home health care that is now being spent on a largely private basis. So, you are talking about very large sums of money for a lot of people.

Mr. FIRMAN. Mr. Brown, we agree with your premise that it would be more efficient and better to have a social insurance program spread across the entire population. However, we are concerned that it may not be politically feasible. However, I would point out that there has been a provision that has sometimes been in the plan and sometimes out, and I could not find it in this version of the Act, which talked about a voluntary public, \$30,000 nursing home insurance plan, where people could opt for a portion of their Social Security benefits to pay for that. I think that is worth considering.

These arguments about cost it seems to me are sort of facetious. We are going to wind up spending the same amount of money for long-term care in this country, regardless of whether it is publicly or privately funded. The only question is do we spread risk and do it equitably, or have the current mish-mash that we have now?

Mr. BROWN. Thank you, Madam Chairwoman.

Mrs. COLLINS. Thank you. Mr. Firman, in past hearings the Commerce, Consumer Protection and Competitiveness Subcommittee has heard testimony about the practice known as post-claims underwriting, in which some insurers avoid paying claims by citing technicalities at the time a claim is filed, that are used to argue that the policy should never have been sold in the first place. Now, does the language in the bill affecting this practice sufficiently protect the consumers, in your opinion?

Mr. FIRMAN. Madam Chairwoman, no. In our opinion, it does not. I would be happy to furnish to your committee a detailed analysis of the provisions in the bill, as compared to section 7 of the NAIC Model Law. The NAIC has spent several years on this and has come up with what we consider to be much better consumer protections and standards which, I might add, the industry has supported quite well also.

Mrs. COLLINS. Would you say the provisions regarding notification don't require it to be sufficiently prompt? Also in the case of the policy being canceled due to misrepresentation of health status, would you say there is no sufficient link between the misrepresentation and the conditions in which the benefits are sought?

Mr. FIRMAN. Yes, I would agree with that.

Mrs. COLLINS. OK. Thank you.

Ms. Bern, how would the new Federal program for home and community care in the President's bill affect home and community care benefits under existing long-term care policies?

Ms. BERN. I think the biggest problem, from the standpoint of providers of existing policies with the new bill is the fact that it will confuse many people. Many people will think they have more coverage in the bill than in fact they do have, and it will further encourage people to ignore or put off the problem of taking care of long-term care needs themselves, those who are personally able to do so.

Mrs. COLLINS. Would you think there would be any premium reductions, in the case of policyholders who would be eligible for the program?

Ms. BERN. To the extent that benefits are provided in the bill that are redundant with policies that are currently on the books, I think insurers will carve around those benefits and either provide rate holidays or additional benefits, or in some ways make the policies meaningful.

John Hancock specifies this to our clients—that we will be willing to alter our policies in the event of a Government program.

Mrs. COLLINS. Mr. Nadel, the President's bill does not require States to provide any 800 number or any other mechanism for consumers to easily, without cost, access information concerning long-term care insurers, and the appropriate methods for filing complaints or otherwise resolving disputes. Now, do you think States should be required to provide a system of this type to facilitate consumer information and satisfaction?

Mr. NADEL. Well, the President's bill, as I said, facilitates a grievance procedure by providing grants. The question is should it be mandatory? I am not sure. I just cannot answer whether it should be mandatory in the bill. I think, as a matter of public policy, the Insurance Departments clearly ought to enable consumers to get information in a standardized way. I just cannot speak as to whether that ought to be written into the act.

Mrs. COLLINS. Do you think an 800 number is so unusual that perhaps it would cause a problem if it were written into the act that each State ought to have an 800 number?

Mr. NADEL. Of course not. It is very standard. I would hope though that the Insurance Departments would do better with 800 numbers on this than in other things or, in fact, that other—that of many other Government agencies do with their 800 numbers. So, just writing it in does not mean it is going to happen the way we would want it to happen.

Mrs. COLLINS. Mr. Firman, do you want to take a shot at that?

Mr. FIRMAN. Yes. I would like to say that I applaud the sections which require better consumer information. I agree that 800 numbers would be useful. However, there are a couple of sections where I think there are some potential conflicts of interest, which the committee ought to look at.

Mrs. COLLINS. OK.

Mr. FIRMAN. One is section 2321(e)(2), which requires companies to provide comparisons of their policies to policies offered by other private insurers. I do not think you can trust one company to provide a fair comparison of its coverage to another. I think the approach actually used in Medigap makes much more sense in section 4012(f)(1). It requires the Secretary or the State to provide this information, and then assesses the companies for the cost of provid-

ing it. I think that is a much better way to get the job done. It is not reasonable to ask John Hancock to tell you how its plan compares to UNUM.

Mrs. COLLINS. Well, Ms. Bern, back to you. In your written testimony you voice your opposition to section 2326(b)(2), concerning the assessment of benefit eligibility on the basis that, and I am quoting now: "Transferring the claim adjudication function to an outside party would expose the insurer to unintended claim liabilities."

My question is are you suggesting that in order for such a determination to be fair, it ought to be made by the insurer, rather than by an impartial decisionmaker?

Ms. BERN. Yes, I am. At present, that is the way that claims are adjudicated. In fact, if the insurer is the person or the entity who has responsibility to perform under the contract, then that entity is both responsible and liable for performing that contractual obligation correctly. If the entity is on the hook for the risk, they have to be able to determine whether or not the situation meets the terms of the contract.

Mrs. COLLINS. Mr. Firman?

Mr. FIRMAN. Yes. This has been an area of particular concern to us, because what we have seen is many companies—or many of the problems arise from companies, when it comes time to pay claims, they will lose the paperwork, they will ask for more documentation. Keep in mind, we are talking about people who are, by definition, sick, and perhaps have dementia. I think it would be very important to have a better, more expedited appeals process by which companies can't delay for 6 months to a year and literally hope the patient dies before they collect claims. We see many of those situations now.

Mrs. COLLINS. Mr. Wyden.

Mr. WYDEN. Thank you, Madam Chairwoman.

Ms. SPENCER, on this commercial that AFLAC is running that has been on the air a great deal, it seems to me that the senior citizen gets hurt at the ball game, and his pals at the office tell him that they can help him by buying insurance at AFLAC. Is AFLAC—and this is what I get out of the commercial—saying that it is going to cover people who are already injured and that is what insurance is all about?

Ms. SPENCER. No, Congressman. I believe the person is a regular working employee. He is not intended to be a senior citizen and/or a non-working senior citizen. Also, I think the implication is that they already have AFLAC, and pay—lets—help him file a claim under his existing policy that can help with some extras, some non-covered charges.

Congressman, if I might clarify something I said in response to your question earlier. I am not sure I made myself entirely clear. On the subject of the Federal prescription of standards for some of these policies, we would be supportive of that if the Federal Government would also take over the rate approval mechanism. Because, as I said, there is a conundrum when the State Insurance Commissioners are given the task of protecting consumers and insuring solvency, and they are handling one end of the process and the Federal Government is handling the other. We would much

prefer somebody handling everything. If it is the Federal Government, that would be OK with us. I am not sure I made that point clear.

Mr. WYDEN. No. It seems to me you are calling for Federal rate setting, which—I thought you all were breaking some new ground here today. For HIAA to call for Federal rate setting.

Look, we wish to work with you on this matter. I just think these dread disease policies, as a general rule, are not worth much more than the paper they are written on. I want to at least see some basic consumer protection standards across the board so that Mr. Nadel does not go out here and write us another 5 years worth of reports, as he has in the past on how the policies are worthless.

Mr. Nadel, let me ask you a question about the report you gave me this summer. You noted that insurers project higher lapse rates in their official filings with the regulators than their actual experience demonstrates. This seems to me, again, evidence that we have still got the big players out there gaming the system. What occurs to me is, if they are projecting higher lapse rates than the experience warrants, one, they can charge lower premiums and then come back and nick the senior citizens down the road, you know, for more cash, or, two, we get into the solvency kind of problem at some point later down the road. Is that the likely set of scenarios, if people are projecting higher lapse rates and experience?

Mr. NADEL. Well, that is the direction, Mr. Wyden. Because, if you are projecting a higher lapse rate, you obviously are projecting lower claims down the line, so you can charge lower premiums. We did not charge bad faith on the part of the insurers though. That may be the result. We are not saying that is their motivation. The expected lapse rate turned out to be lower, at least in the first year. What we don't know—since the——

Mr. WYDEN. It was 20 percent lower, wasn't it?

Mr. NADEL. Right. Right. Sure, 15 versus 20.

The big unknown is what happens in the out years. The expected lapse rate is about 50 percent for the companies that we reviewed. If we look at 5 years and see what they are, then we will see how much lower they would be.

Mr. FIRMAN. Mr. Wyden, can I make one comment about that?

Mr. WYDEN. Sure.

Mr. FIRMAN. I think there is another mystery to this lapse rate data, because, if in fact, as Ms. Bern said, that John Hancock only has lapse rates of 7 or 8 percent, I would wonder why nonforfeiture protection is going to be so expensive? So, there are few people going to lapse and potentially being that situation. So, I think there has been a lot of gaming going on this issue of lapse and also on the cost of nonforfeiture benefits.

Mr. WYDEN. Mr. Nadel, is it correct in saying that you all want to see the industry figures on these lapse rates, as I think something like 10 years out and they have not been willing to give them to you for your analyses?

Mr. NADEL. Yes. We did not examine records. The companies were talking with us and forthcoming in varying degrees. I would hate to characterize it as stonewalling, because, at least the industry association did share some data with us.

It is really unclear how far out you can get useful exact lapse rate data, because the product has changed. It also may be that, as Mr. Firman said, or as Mr. Firman suggests, if you go farther out and you get better and better policies, so that—and also policies sold more appropriately, it may be that fewer people will lapse. That, of course, would make nonforfeiture benefits that much less expensive.

Mr. WYDEN. Thank you, Madam Chairwoman.

Mrs. COLLINS. The time of the gentleman has expired. Mr. Stearns?

Mr. STEARNS. Thank you, Madam Chairwoman.

This is really just a comment. Ms. Spencer, you might think about these words. Global budgets, premium caps, setting a ceiling, controlling the supply of providers, controlling the utilization by limiting units of service, restricting eligibility through number of ADL's or income controlling demand through co-payments, controlling price or reimbursement rates. All of those have to be a little bit of a concern for you, I suspect. Those are different ways—probably Nancy might be a little concerned when you hear those cost controls in the area of long-term, because that is certainly not the free market, and just moves us into price controls.

My question for you, Nancy, is, under the President's plan, the National Long-Term Care Advisory Council is to make recommendations to the Secretary of HHS concerning limits on agents' commissions and enumerates various sales practices requirements. What do you think about applying a cap to insurance agents' commissions to reduce the potential for inappropriate sales and to assure good value for the consumer?

Ms. BERN. I do not think limiting agents' commissions really gets directly at the problem. What we are dealing here with is unscrupulous or inappropriate behavior. Setting rate caps does not prevent an agent from making an inappropriate sale. I think it is much more appropriate to talk about education, very clear rules, and very strict enforcement and penalties.

Mr. STEARNS. Mr. Firman?

Mr. FIRMAN. We have watched this market very carefully. There are companies that pay 78 and 80, 90 percent commissions in the first year. Those are the companies that disproportionately have agents that practice coercive practices and many marketing abuses. I do not think it is a coincidence. I think the more incentive you have for an agent to make a first-year sale, regardless of what happens in the second year, people follow the behavior. So, I think some appropriate limits on agent commissions are suitable. I think it makes sense to leave it up to the Advisory Commission to determine what they should be.

Mr. STEARNS. Mr. Willging, you indicate that the Federal Government ought to do as much as it can to maximize the private sector role in the private/public long-term care partnership. Would the Health Security Act do as much as can be done? Perhaps you might want to elaborate on what you would suggest.

Mr. WILLGING. Well, at the risk of not answering yes and no, I think, in terms of focusing on long-term care insurance, recognizing the need for consumer protection, tax clarification and education, yes, the President has taken a very important step.

As I mentioned in my comments, Mr. Stearns, the issue is developing the concept of value in the mind of the consumer. As long as we have this confused signal coming out of the President's proposal—part of it talks about long-term care insurance, part of it talks about the public/private partnership, the other part of it talks about a program which used to be called an entitlement, and, in one of its iterations, has not lost the term cap entitlement—but, quite frankly, leaves the impression, well, gee, if I do not do anything, maybe 5 years, 10 years, 15 years out, the Government will finally put in place a cradle to grave pay for everything long-term care program. With that kind of uncertainty sitting out there, obviously, the question of value is not going to be adequately addressed.

I think there has to be a clear statement. Either we are for or we are not for the concept of public/private. Either we feel that the Government will cover everyone, regardless of financial status, or we feel people with resources need to take their own responsibility. Until that issue is definitively clarified, we will not have done what we can do in terms of creating that concept of value in the mind of the American consumer.

Mr. FIRMAN. I would have to take issue with that. I think this bill sends very clear signals to the American public that they ought to consider buying private, long-term care insurance. First of all, it provides public insurance for home and community-based care, which is the most difficult part for the private market to ensure, it sets Federal standards, which tells the consumer that these policies will be good, and provides tax clarification, which means it will help consumers to purchase these policies and provides money for consumer education and enforcement. I am not sure what else the Federal Government could possibly do to encourage people to buy private long-term care insurance.

Mr. STEARNS. Madam Chairwoman, I will yield back the balance of my time.

Mrs. COLLINS. Thank you.

Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Madam Chairwoman.

A number of the health plans that have been submitted by Members of Congress, including the one that I helped to write, include the use of IRA accounts or Medisave accounts. Dr. Rowland, who has left, but, Dr. Rowland mentioned it in his opening remarks.

Mr. Nadel, do you have an opinion about that concept?

Mr. NADEL. The problem with relying on the individual for this or for long-term care insurance is what happens down the road if the person does not do it? Now, we can have—unless you want to make it compulsory, and even if it is compulsory, it is probably harder to enforce against individuals than against businesses. You are confronted with the individual who does not do it and who knows full well that we are not going to let people die on the streets. So, it—I am not sure it creates the kind of incentives you want. If there could be some assurance that, in fact, everyone, without exception, would carry their own weight in that way, then it is an idea that could certainly have some merit.

Mr. BILIRAKIS. But, you use the word "rely" and "compulsory," and the idea is to come up with ways to encourage or make it easier to buy long-term care insurance.

Ms. Bern, do you have any comments—Ms. Spencer, regarding being able to purchase long-term care insurance through such a concept?

Ms. BERN. I think the fact that the private long-term care insurance market is growing and growing very rapidly is evidence that there is interest in the product. People who can by this product do want to have choice. They want to provide for their own long-term care needs. Something like this which would stimulate and give some advantage to doing so, I think would be welcomed in the market.

Mr. BILIRAKIS. Ms. Spencer, do you have any comments?

Mr. WILLGING. I think one thing is clear, Mr. Bilirakis. There is no absolute model as to how we do this. We are learning. We tend to forget sometimes that 15 years ago there were 1 or 2 companies selling long-term care insurance, and we had 50,000 policies sold. We have now sold close to 3 million, and we have got 135 companies.

I think what we have to do is explore all sorts of opportunities and avenues, which would allow us to better marshal private resources to help pay the tab for long-term care; reverse equity mortgages; IRA's; as Mr. Rowland suggested, no penalty if you remove money from an IRA to buy long-term care insurance; different taxation approaches to pre-death benefits under life insurance. I think we would try everything which will ease the continued growth of the long-term care insurance market, and not settle on just one cookbook approach, because we have not gotten that yet.

Mr. BILIRAKIS. Right. That certainly is not the intent, Mr. Nadel, I hope you realize that.

Mr. Firman does not seem to be supportive of a means test concept. The rest of you would be. Mr. Nadel, of course, is noncommittal, as he should be. The bottom line is affordability. The need would certainly be there. We all would agree the need is there. It is a case of affordability. Either the Government does it all again or else the Government exercises the role that is more suitable for the Government, and that is to try to be a teacher, to try to motivate, to try to come up with plans to encourage the private sector's involvement, and to encourage individuals. I see somewhere in here—Ms. Bern, you list the nationally-recognized firms that are employer group clients at NYNEX. I am trying to give you equal time, you see, with AFLAC, Westinghouse, Bank America, et cetera, et cetera. You are referring to long-term care insurance, in addition, of course, to health care.

Ms. BERN. Yes.

Mr. BILIRAKIS. Are the premiums for the long-term care portion paid for by the companies? Are they shared with the employees? How does that work?

Ms. BERN. At this point in the industry, the product is almost exclusively paid for by the employees. The corporation offers the program, but the employees sign up and pay for it themselves.

Mr. BILIRAKIS. What kind of a percentage is there in terms of the employee's willingness to sign up and pay for it themselves?

Ms. BERN. It varies a lot. I think the National average is perhaps somewhere between 10 and 15 percent. We also offer it to spouses, retirees, spouses of retirees and even parents and grandparents. So, an employee can pull in a fairly wide population.

Mr. BILIRAKIS. Parents or grandparents of the employee?

Ms. BERN. Yes.

Mr. BILIRAKIS. I see.

Ms. BERN. Or the spouse.

Mr. BILIRAKIS. I was going to ask, Madam Chairwoman, if any of these people, particularly Mr. Firman, were pulled into the process of determining the President's plan. I know my time has expired. Maybe I would afford that question, for the record, and ask them to submit an answer in that regard, with your permission.

Mrs. COLLINS. Without objection, it is so ordered.

I also have a number of questions here that I am going to submit and ask that the responses to these questions be returned in a very speedy fashion as well. Most of my questions deal with supplemental insurance, which is a matter that we did not get into a great deal at today's hearings.

I want to thank all of you for appearing before us today.

Mr. BILIRAKIS. Yes. My thanks too.

Mrs. COLLINS. Thank you very much. I know that your testimony has been very beneficial to our hearing today to both of our subcommittees. Thank you very much.

The hearing is adjourned.

Mr. WILLGING. Thank you, Madam Chairwoman.

[Whereupon, at 4:25 p.m., the subcommittees were adjourned, to reconvene at the call of the Chair.]

HEALTH CARE REFORM Medical Malpractice

WEDNESDAY, NOVEMBER 10, 1993

HOUSE OF REPRESENTATIVES, COMMITTEE ON ENERGY
AND COMMERCE, SUBCOMMITTEE ON HEALTH AND THE
ENVIRONMENT, AND THE SUBCOMMITTEE ON COM-
MERCE, CONSUMER PROTECTION AND COMPETITIVE-
NESS,

Washington, DC.

The subcommittees met, pursuant to notice, at 9:55 a.m., in room 2322, Rayburn House Office Building, Hon. Cardiss Collins chairwoman, Subcommittee on Commerce, Consumer Protection and Competitiveness and Hon. Henry A. Waxman, chairman, Subcommittee on Health and the Environment, presiding.

Mrs. COLLINS. This joint hearing on the medical malpractice issues of the Health Security Act will come to order.

I want to welcome you to our last joint hearing, at least for the time being, on the Health Security Act. For the rest of the session, each subcommittee will be holding separate hearings, and I want to say that it has been a pleasure to work with my colleague and friend Henry Waxman.

The occurrence of malpractice in the course of medical treatment is, unfortunately, a fact of life. Although it is certainly an exception to the usual high standards of quality in America's medical experience, when it occurs its consequences are often grave. Sometimes malpractice results in only incidental inconveniences. But other times it has resulted in serious life-altering disabilities, and even death.

Certainly, no one would argue that a patient who was actually injured in this way should not receive compensation. But, especially in recent years, there has been a great debate over the terms and extent of such compensation.

The debate has become one of national interest as the proponents of reform have suggested that malpractice suits result in costly damage awards that add substantially to our Nation's health care expenses. Yet, studies show that only a very small percentage of medical injuries due to negligence actually make it to the courts, and even fewer result in damages awards. Perhaps most peculiar of all is the assertion that denying an injured patient full compensation is somehow fair and that, with the minimal impact it has on health care costs, it will be a cure for our rising health care costs.

Proponents of malpractice reform also suggest that the malpractice system is responsible for spiraling health care costs

through the practice of "defensive medicine." Yet, while additional tests and procedures are often blamed for defensive medicine, there are many other reasons why physicians may choose to administer these tests and procedures, including the desire to be certain of a patient's condition or diagnosis.

Strangely, one idea that the White House considered during the summer to actually limit the liability of physicians, which would be to establish what is known as "enterprise liability", was rejected by the physician community. If defensive medicine is, in fact, a problem, the solution was rejected by those very people who would benefit the most from it. Instead, enterprise liability was offered as only a demonstration project.

Those who oppose major reforms in this area attribute much of the added costs of malpractice insurance to the liability insurance industry and the observation that the incidence of malpractice itself has increased over the years. These factions coalesce around the principle that a patient who is injured through an act of medical malpractice must have full access to the same legal remedies that victims of other torts have, so as not to foster great injustices. In addition, they argue that reforms of the type that some propose would have a net negative effect on the quality of care that health care providers offer their patients.

Meanwhile, numerous academics and other observers have studied various aspects of the issue. One study has found that lower-income Americans are much less likely to file malpractice lawsuits for their medical injuries due to the many financial and procedural obstacles that already are posed.

Another study found that defensive medicine is not a major factor in medical costs and that much of the treatment that is cited as defensive would occur even if major malpractice reforms were enacted. And another found that most victims of negligent medical care simply do not seek compensation for their medical injuries.

Finally, with the variety of malpractice rules which currently exists in the States, there has been much trial and error with regard to malpractice reforms. The experiences of the States have shown that health care costs have been spiraling in States that have already enacted comprehensive malpractice reforms, just as in States without them. Before we consider preempting State laws, we need to carefully examine this information to see what is working and what is not.

This is a very important topic, and I look forward to the testimony.

Mr. Waxman?

Mr. WAXMAN. Thank you very much, Madam Chairwoman.

I also want to express my appreciation to you for the work we have done together in holding these joint hearings and recognize the fact we have a lot of work to do together to enact legislation.

Today's hearing does have an impact on the question of health reform. The issue of medical malpractice is a question not only of the appropriate compensation for those who are injured by virtue of a tort, the malpractice that might have been performed by some health practitioner, but the consequences to the health care system for the increased costs due to the liability system itself and the

kind of medicine that is practiced in fear of being held liable after the fact.

I think we need to look at this issue from three perspectives. Obviously, we need to look at it from the perspective of the patient. We need to understand, in the administration's proposal or other ideas in this area, what will be the consequence in terms of adequately compensating people who deserve to be compensated because they are victims of malpractice.

And, if we are going to change the current law, are we going to deter the—are we going to still have the deterrence that a medical malpractice lawsuit might bring to malpractice itself, to negligence by those who might otherwise behave in an appropriate way because of the fear of being sued later.

The second perspective, equally obvious, is from the perspective of physicians and the health care system. There is a cost for malpractice insurance that in many places has increased, sometimes dramatically, and there is a cost to health care system and services due to the fact that many practitioners will perform services they do not think appropriate but do so only for fear that they are going to be second-guessed later on.

And then I think a third element for our consideration is the reality that tort law, medical malpractice law has been at the State level, and if we are going to override this area that is traditionally left to the States by preempting tort law, we should be confident that the right of the patients won't be jeopardized and that we are not taking a system that is geared to be run by the States even more and removing their ability to experiment with different alternatives to one Federal law in this regard.

I look forward to the testimony of our witnesses.

Thank you.

Mrs. COLLINS. Mr. Bliley?

Mr. BLILEY. Madam Chairwoman, I would like to yield my place to Mr. McMillan, who has another hearing and will have to leave shortly.

Mrs. COLLINS. Thank you.

Mr. McMillan?

Mr. MCMILLAN. I thank the gentleman for yielding, and Madam Chairwoman.

Surgeon General Koop, before the introduction of the President's plan, stated that roughly 25 percent of health care costs are unnecessary. That is an enormous amount of money, pretty close to \$200 billion.

Getting at the cost drivers in health care is essential to any successful health care reform, whether you are talking about the public or the private cost. The latest study I have seen attributed direct malpractice cost, that is, judgments and fees of attorneys, at about \$8 billion totally. But this is only the tip of the iceberg.

I have had hospitals in my district tell me that defensive procedures probably constitute up to 20 percent of bill-out rates. This is in a major hospital, a very sophisticated hospital, a low-cost hospital.

I am not going to say all that is because hospitals and doctors are running around in a craven fear of being sued. But it is interwoven with the whole pattern in medicine today in which proce-

dures are there, testing capabilities are there and they get used, because there is no one questioning whether they really need to be used or not. And if they are not used, clearly that creates fertile ground in which lawsuits can take place.

Furthermore, the crazy-quilt pattern of medical malpractice laws throughout our States make compliance very difficult. There are many providers—doctors, hospitals and others—out there who believe that some Federal legislation dealing with the issue of standards of practice are necessary to address this issue.

That is not our subject today, but practice standards are certainly interrelated with the whole issue of malpractice. They are interrelated with the issue of adequate measurement of outcomes. They are essential to determining logically what is the real cost of a standard basic package of health care, and I am hopeful that at some point in this process we will address that, because I think it is interrelated with what we are dealing with here today.

But a more important way to address this overwhelming cost driver, we will call it defensive and unnecessary procedures, in our system is to have serious comprehensive tort and medical malpractice reform as part of this package.

In the Health Security Act, the President pays lip service to it, but what he does doesn't go far enough, and I think that is one of the things that we must examine critically here today. For instance, unlike what is a serious Republican alternative, the President makes no provision for capping noneconomic damages, thus allowing for a continuing upward spiral of judgments for noneconomic damages that are unnecessary. Republicans, on the other hand, set that cap at \$250,000.

Alternative dispute resolution is a key part of the Republican plan, and I think a key part of any serious plan. While the President makes that provision optional, it doesn't make it mandatory, and without an English rule on litigation on appeal, which requires the plaintiff to pay the defendant's legal fee should they lose, there is no economic incentive to try to work things out through alternative dispute resolution, and I think that is an important feature.

I have introduced a bill before any of the packages were put together, H.R. 1989, which, as far as I can see, sets a very reasonable standard for any kind of malpractice legislation that we would have. It basically mandates alternative dispute resolution for anyone who receives benefits from a government program, including tax deductibility of their plans. The idea is to make people use alternative dispute resolution set up by the States before they resort to litigation.

They would have the right to appeal decisions from alternative dispute resolution to the court system, and anyone should certainly have that right. But I think that if we are going to really get serious about streamlining this process, we are going to have to have an alternative dispute resolution system that works.

ADR's wouldn't deprive anybody of access to judgment for malpractice that has done them damage. On the other hand, it would probably give more people greater access to legitimate claims because they wouldn't have to necessarily incur the heavy cost of litigation in court.

This is so logical that even the head of the American Bar Association endorses it, and I think 88 percent of the American public is in favor of it. I have even had trial lawyers in North Carolina, my home State, who have been active politically on this issue in the Senate of North Carolina, coming out in favor of it.

So, it is not something that we need to run around and cravenly hide from trial attorneys on. I think it is something we need to face honestly and openly. And I think if we are willing to do that we can come up with something that will have a decided impact on one of the major cost drivers in our health care system without depriving any citizen of their legitimate rights to just compensation.

I thank the gentleman from Virginia again for yielding, and yield back the balance of my time.

Mrs. COLLINS. Dr. Rowland?

Mr. ROWLAND. I have no opening statement.

Mrs. COLLINS. OK. Mr. Bliley?

Mr. BLILEY. Thank you, Madam Chairwoman.

I ask unanimous consent to insert my full statement into record, much of which my colleague from North Carolina has already outlined.

But there is one other point I would like to make, and that is in the administration bill, the bill contains a host of provisions that establish a series of private rights of action which could have an enormous effect on malpractice litigation, including private rights of action to enforce State responsibilities, to enforce Federal responsibilities, and to enforce the responsibilities of the alliances. These provisions are a complete contradiction to the notion of malpractice reform, which is to remove the resolution of disputes from the courts.

And I thank the Chair and yield back the balance of my time.

Mrs. COLLINS. Thank you.

[The opening statement of Mr. Bliley follows:]

OPENING STATEMENT OF HON. THOMAS J. BLILEY

Mr. Chairman, I would like to join you in welcoming our witnesses today. Malpractice reform is long overdue in this country and I am pleased that the committee is focusing some long needed attention on it. No one disagrees that the goal of the malpractice system is to compensate patients fairly who experience a medical injury. However, the current system falls far short of that goal. Compensation is not consistent, timely or predictable. Nor is it available to all who may qualify.

Our malpractice system has also led to extremely serious access to care problems, particularly in obstetrics. Yesterday's New York Times reports on an interview with Mrs. Clinton in which she states unequivocally that "universal coverage with comprehensive benefits" is a non-negotiable element of the President's health reform package. My point is that access to insurance coverage does not translate into a guarantee of access to care. Doctors cannot be forced to practice in a specific field of medicine. Unless health reform seriously addresses the malpractice issue, it will not solve some of today's most serious access problems. Some of our witnesses today will testify that almost 1 out of 8 OB/GYN's have quit obstetrics and almost one quarter have decreased the amount of high risk obstetrical care they provide because of liability risks.

In a speech before the American Medical Association this summer, Mrs. Clinton pledged that the administration would "offer a serious proposal to curb malpractice problems". A review of the malpractice provisions in the administration's proposal demonstrates that the reality falls short of the rhetoric. While I am pleased that the plan does begin to address some malpractice issues, it only provides lip service to some and completely ignores some very important ones.

I am pleased that the plan does provide for a modification of the collateral source rule by providing for a mandatory offset against awards received from other sources.

Nearly half the States have not modified this rule and I think it has been well documented that it saves money. It also removes the simple inequity of providing multiple awards for the same injury. Periodic payment of awards is also included in the Clinton plan. This would help reduce costs while insuring that the money will be there for the plaintiff when needed. I think the demonstration projects on both enterprise liability and practice guidelines are worth pursuing and will yield valuable information one way or the other.

I am very supportive of the concept of dispute resolution because I think we need an efficient administrative compensation mechanism, but as proposed in the Clinton plan, it simply will not work. Under the administration's proposal, patients will be required to submit their claims for alternative dispute resolution; however, if the consumer is dissatisfied with the outcome, he can go to court. It could simply turn into a valuable discovery period for the plaintiff. To be effective, it is important to require plaintiffs to pay the defendant's legal fees if the plaintiff rejects the decision, goes to court and does not receive higher awards.

The provision in the Clinton plan limiting attorneys fees to one third of an award merely codifies current practices and is simply rhetorical window dressing.

My biggest concern with the malpractice provisions relate to what is left out. There are no limits on noneconomic damages which constitute about half of total payments and which generate much of the unpredictability and inconsistency of awards. Such limits would make outcomes more certain and predictable thereby leading to quicker settlements and lower administrative costs. Since about half of the States have no limits on these damages, universal adoption of such a reform could have an important effect. It should be noted that the recent study on the "Impact of Legal Reforms on Medical Malpractice Costs" by the Office of Technology Assessment concluded that "the one reform consistently shown to reduce malpractice cost indicator is caps on damages."

In addition, the merits or lack thereof of the malpractice provisions aside, the bill contains a host of other provisions that establish a series of private rights of action which could have an enormous effect on malpractice litigation including private rights of action to enforce State responsibilities, to enforce Federal responsibilities of the alliance. These provisions are a complete contradiction to the notion of malpractice reform which is to remove the resolution of disputes from the courts.

Mrs. COLLINS. Mr. Towns?

Mr. TOWNS. I would like to ask permission to include my entire statement in the record.

Mrs. COLLINS. Without objection, so ordered.

All statements will be made a part of the record.

Mr. TOWNS. Let me thank you, Madam Chairwoman, for this hearing.

There should be no doubt or concerns about the fact that malpractice is pushing up the cost of medicine. The fact that doctors are involved in terms of sort of a preemptive strike; that they are doing extra tests and, of course, that costs a lot of money. Because when they send it to the labs, the labs are involved in it, and, of course, the staff of the lab have to be paid as well.

Malpractice in the area that I come from runs as high as \$90,000, and I have heard that in some areas it goes as high as \$137,000.

In all of Central Brooklyn, which is over 500,000 people, there is not one OBS in private practice, and I think that that is something that has to be dealt with. So, if we are going to really reform our health care, we have to look at tort reform. I think that that is a must.

So, Madam Chairwoman, I would like to thank you for having us to focus on this, because I think that any health care reform must consider tort reform.

Thank you very much. I yield back.

Mrs. COLLINS. Thank you.

[The opening statement of Mr. Towns follows:]

OPENING STATEMENT OF HON. ED TOWNS

Mr. Chairman and Madam Chairwoman, today's hearing on malpractice reform is one of the most critical issues to true reform of our current health care system. Our efforts at cost containment and expanded access to health care services will be useless without improvements in our current malpractice system.

There should be no doubt that concerns about malpractice suits drive up the cost of medicine. Doctors engage in a sort of "pre-emptive strike" approach to the practice of medicine. Every possible test is ordered whether or not the physician believes that it is medically necessary. He or she orders that additional test and/or treatment in order to build a defense against a potential malpractice claim. These additional tests and treatments are not without cost. There is not only the cost of the procedure itself but also we have to pay the salary of the person who administers the procedure and the person who analyzes the results.

Concern about malpractice insurance costs also have a direct impact on access to quality health care. In a State like New York, the very cost of malpractice insurance has driven many physicians out of practicing medicine. Anytime you have to spend close to \$90,000 on malpractice premiums that has got to have an impact on the rates you charge patients, what patients you accept in your practice and also where you decide to practice. Right now, today, in central Brooklyn, a borough with over 500,000 people, there is only one OB-GYN who is willing to accept Medicaid patients for obstetric care. Let me emphasize this point—we are talking about \$90,000 before you rent an office, purchase medical equipment or hire office staff. And I have heard that doctors pay as much as \$137,000 in insurance premiums.

Testimony which will be presented to us today reveals that many claims are brought where there has either been no negligent injury or the claim has been dropped or settled without payment. This assessment suggests that suits are often filed not because of a real concern about negligence but because there is a disagreement in treatment methodology between the doctor and the patient. From that perspective, the certificate of merit and the alternative dispute resolution system in the administration's plan should ameliorate some of these frivolous claims.

On the other hand, I believe we should carefully examine the Office of Technology Assessment's finding that caps on damage awards have had a significant impact on reducing malpractice premiums on the State level. After all, we are the only country in the industrialized world that permits unlimited compensation for non-economic damages. Additionally, I believe we need to carefully review whether the one-third limitation on contingency fees impacts the ability of the poor to seek legal redress.

I regret that I am chairing a hearing within the hour so I will not be able to remain to hear all the witnesses but I look forward to working with our two Chairs and my colleagues to address real malpractice reform when this legislation is marked up next year.

Mrs. COLLINS. Mr. Klug?

Mr. KLUG. No opening statement.

Mrs. COLLINS. Thank you.

Mr. Brown?

Mr. BROWN. No opening statement, Madam Chairwoman.

Mrs. COLLINS. Thank you.

Mr. Franks?

Mr. FRANKS. No opening statements, Mrs. Chairwoman.

Mrs. COLLINS. Thank you.

Mr. Pallone?

Mr. PALLONE. I just wanted to say briefly, Madam Chairwoman, that I think this is a very difficult area. That is, I guess, obvious to everyone.

I find, myself, that when I talk to constituents that they all clamor and say that we need malpractice reform and that they see that as a major part of the increasing cost of the health care system.

On the other hand, if somebody does have an injury or somebody feels that they have been wronged and then they find out that they might have some kind of restriction on their ability to sue or on the amount of damages that they can recover, they are quick to

scream and say, "Gee, that is terrible. That goes against my individual liberties, that is un-American."

So, I think it is very difficult to weigh the two, and that is why I think this hearing is very important and why it is going to be an important part of whatever we do as part of the health care reform.

Thank you.

Mrs. COLLINS. Thank you.

Mr. Greenwood?

Mr. GREENWOOD. No opening statement.

Mrs. COLLINS. Mr. Moorhead?

Mr. MOORHEAD. Thank you, Madam Chairwoman.

I am especially pleased that we are focusing today on medical liability issues. For sometime this has been an issue of interest to my constituents, and especially to me as a member of both the Energy and Commerce and the Judiciary Committees.

Significant and meaningful malpractice reform must be a part of any future health care reform bill because malpractice costs are integrally related to the rising cost of health care. They are linked to increased utilization of services or defensive medicine, to increased insurance and legal costs, and finally through increased cost for services to the patient.

We are wasting precious resources on frivolous cases and we should resolve those cases which are legitimate in more cost effective ways. Studies estimate these costs to be, conservatively, \$20 to \$25 billion a year. The malpractice system is not the only cause of rising health care costs, but it is a major contributor and one that we can address without jeopardizing protections for legitimate victims.

In my own State of California we have seen how successful medical malpractice reform efforts can be. In 1975, after tremendous cooperation between all of the parties, the State legislature passed MICRA, the Medical Injury Compensation Reform Act. For 18 years it has successfully confronted serious excesses in the malpractice system, while simultaneously providing fair redress for those who have truly suffered from substandard care.

If the Congress wanted to implement a system like MICRA now, there is already legislation pending to do just that. H.R. 3080, the Affordable Health Care Now Act, which I and 130 other members of the House have cosponsored, contains the kind of strong malpractice reform provisions I want to see enacted.

I wish that the President's bill contained stringent malpractice reform like those in H.R. 3080, but the Health Security Act really does not go far enough. I am increasingly hopeful, however, that Congress will not miss the opportunity to make real progress.

I look forward to hearing from our witnesses today.

And thank you, Madam Chairwoman.

Mrs. COLLINS. Mr. Stearns?

Mr. STEARNS. Thank you, Madam Chairwoman.

Today it is universally recognized that we need to reform the medical malpractice system. Individuals representing views as divergent as former President Bush and President Clinton, House Members Bob Michel, John Dingell, Jim Cooper, Senator John Breaux, and Orrin Hatch, all believe that the time for medical mal-

practice reform has come and included such reforms in their health care proposals.

Seventy-seven percent of all Americans believe that medical malpractice reform is an important key to reducing spiraling health care costs. Medical malpractice is a lot like the Superfund, an issue quite familiar to Energy and Commerce Committee members. All of the dollars are going to the lawyers and very little is going to "cleanup." According to the Rand Corporation, only 43 percent of every dollar spent on medical liability litigation reaches injured patients as compensation. The rest is spent on attorney's fees for both sides. Litigation expenses and insurance administration costs.

With skyrocketing health care costs, Americans cannot afford such an inefficient system. Unfortunately, it is the ordinary man or woman who is suffering. Under the current system, Americans are being denied access, first, to particular areas of practice, and, second, to the courts.

First, one-third of U.S. physicians avoid particular areas of medical practice, even though they are qualified, because of malpractice concerns. Millions of pregnant women in rural areas and in the inner city are having difficulty finding obstetricians and gynecologists, especially if they have a high-risk pregnancy.

Second, many Americans are denied access to the legal system. Only the well-off can afford to pursue their claims in court, since on the average it takes longer than 2 years to resolve a medical liability claim from the time it is filed. Lawyers consider claims with award potential or plaintiffs who can carry the costs throughout the case.

Under today's system, only 6 percent of patients who experience adverse outcome as a result of negligent care receive compensation. Today's system seems to benefit only those who can afford to pursue a claim and not the ones who are truly injured. There has to be a better way.

Therefore I encourage my colleagues and the President to pursue all reasonable reforms that will allow for swift and just compensation of injured patients, but eliminate those aspects of our court system which drives up costs that are ultimately passed on to the consumer, and I look forward to hearing our witnesses.

Thank you, Madam Chairwoman.

Mrs. COLLINS. Thank you very much.

Let me call the witnesses, please. Our first panel will be Mr. Webster Hubbell, who is the Associate Attorney General with the Department of Justice, and Dr. J. Jarrett Clinton, who is the Administrator for the Agency for Health Care Policy and Research, with the Department of Health and Human Services.

Won't you come forward, please?

Good morning. Both of you have testified before congressional committees before, and you know that we operate under the 5-minute rule. We are going to do so this morning with the full knowledge that your entire testimonies, as will the testimony of all of the witnesses today, be made a part of the record, and ask that you summarize your testimony in the 5 minutes or so. Thank you very much.

We are going to begin with you, Mr. Hubbell.

STATEMENT OF WEBSTER L. HUBBELL, ASSOCIATE ATTORNEY GENERAL, DEPARTMENT OF JUSTICE, ACCOMPANIED BY J. JARRETT CLINTON, ADMINISTRATOR, AGENCY FOR HEALTH CARE POLICY AND RESEARCH, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. HUBBELL. Thank you, Chairwoman Collins and Chairman Waxman. It is a pleasure to be with you today to discuss the Health Security Act and the administration's proposals relating to medical malpractice reform.

These early hearings which your two subcommittees are holding on key components of the Health Security Act represent an important step in securing adequate health care for all Americans, and we look forward to working with you on this very important project.

I am accompanied today by Dr. J. Jarrett Clinton, who is the Administrator of the Agency for Health Care Policy and Research within the Public Health Service of the Department of Health and Human Services. Dr. Clinton will address questions you may have regarding the National Practitioner Data Bank and demonstration projects in the areas of enterprise liability and the use of practitioner guidelines in resolving medical malpractice claims.

The President's health care reform plan is the most detailed and comprehensive health care reform proposal ever offered. As with other parts of the plan, the President has committed his views to legislation and I am here today as part of the continuing dialogue on those views.

There are many things wrong with the medical malpractice system as we know it today. Some who are injured are perceived to be overcompensated. Others are undercompensated or shut out of the system altogether.

There is little empirical evidence that the malpractice system deters substandard care or promotes the practice of quality medicine. We all know that the civil litigation system can be inefficient and expensive. We know that doctors practice defensive medicine, which at least in part is related to malpractice litigation. While the costs may be hard to quantify, we do know that such practices have contributed to the soaring costs of our Nation's health care bill.

The President's proposal attempts to address the problems with the current malpractice system, while recognizing that the medical malpractice litigation is only one aspect of basic State tort law and jurisprudence. We know that virtually every State has adopted specific malpractice reform since the malpractice liability insurance crises of the 1970's and 1980's, and each of these reforms has been tailored to the unique circumstances of that State. We strongly believe that medical malpractice cases should continue to be litigated primarily in State courts and that medical malpractice reform should respect the fundamental nature of State practice and procedure.

The President's proposal provides two new mechanisms for a more sensible and cost effective approach to resolving medical malpractice disputes. First, it encourages consumers and providers to settle malpractice claims outside of court. Every health plan will be required to develop and have in place at least one alternative dispute resolution mechanism and every claim against a doctor or

other provider must first be referred for alternative dispute resolution before it can be litigated. While ADR is not binding, meaning the consumers' dissatisfied with the outcome can go to court, it is mandatory.

Attempting to settle medical malpractice claims before they get to court has rewards for both patients and providers. Parties suffering real injuries will be compensated sooner, and claimants with smaller claims will have increased access to the dispute resolution mechanism. The plan administrators will be aware of those providers with a track record of claims against them, and physicians may be spared the expense and distraction of defending groundless claims.

For the first time, the names of licensed health care practitioners with repeated numbers of malpractice claimants or sanctions will be made available to the public. Combined with quality measures in the proposal, the public can make more informed choices about the practitioners they choose. With adequate information, consumers can improve the quality of the health care they receive by their choice of practitioner.

The Health Security Act also contains proposed reforms to discourage the filing of frivolous lawsuits and to provide fair and uniform national rules for malpractice awards.

First, the proposed Act limits the amount of lawyer's fees to one-third, which is actually higher in some cases, but States may impose lower limits.

Second, under the administration's proposal, before a lawyer can file a medical malpractice lawsuit he or she has to first consult a qualified medical specialist and prepare an affidavit, including a written report by the medical specialist. The written report must contain the specialist's determination that the specialist has reviewed the medical records and believes there is a reasonable and meritorious claim.

Mrs. COLLINS. Mr. Hubbell?

Mr. HUBBELL. Yes, ma'am.

Mrs. COLLINS. Have you finished your third one? The time really has expired. We had the clock set wrong—this light was set wrong, but the clock was not set wrong.

Mr. HUBBELL. OK. I am sorry.

Mrs. COLLINS. So, if you will finish your final statement.

Mr. HUBBELL. I will be glad to.

Third and finally, we propose that double recoveries be eliminated.

We recognize that this is a very difficult issue. We look forward to working with this committee on this issue.

Mrs. COLLINS. Thank you very much.

[The prepared statement of Mr. Hubbell follows:]

STATEMENT OF

WEBSTER L. HUBBELL

ASSOCIATE ATTORNEY GENERAL

Chairman Waxman and Chairwoman Collins, it is a pleasure to be with you today to discuss the Health Security Act and the Administration's proposals relating to medical malpractice reform. The early hearings which your two Subcommittees are holding on key components of the Health Security Act represent an important step in securing adequate health care for all Americans. The President is grateful for the priority you have given this legislation. Every member of this Administration stands ready and willing to assist you and your colleagues, so that we may realize the prompt enactment of this historic proposal by the Congress.

I am accompanied today by Dr. J. Jarrett Clinton, Administrator of the Agency for Health Care Policy and Research, within the Public Health Service of the Department of Health and Human Services. Dr. Clinton will address questions you may have regarding the National Practitioner Data Bank and demonstration projects in the areas of enterprise liability and the use of practitioner guidelines in resolving medical malpractice claims.

The President's health care reform plan is the most detailed and comprehensive health care reform proposal ever offered. As with other parts of the plan, the President has committed his

views to legislation, and I am here today as part of a continuing dialogue on those views.

There are many things wrong with the medical malpractice system as we know it today. Some who are injured are perceived to be overcompensated; others are undercompensated or shut out of the system altogether. There is little empirical evidence that the malpractice system deters substandard care or promotes the practice of quality medicine. We all know that the civil litigation system can be inefficient and expensive. We know that doctors practice defensive medicine which, at least in part, is related to malpractice litigation. While the costs may be hard to quantify, we do know that such practices have contributed to the soaring costs of our national health care bill.

The President's proposal attempts to address the problems with the current malpractice system, while recognizing that medical malpractice litigation is only one aspect of basic state tort law and jurisprudence. We know that virtually every state has adopted specific malpractice reforms since the malpractice liability insurance crises of the 1970's and 1980's. Each of those reforms has been tailored to the unique circumstances of the respective state court and civil justice system involved. We strongly believe that medical malpractice cases should continue to be litigated primarily in the state courts and that medical

malpractice reform should respect the fundamental nature of state practice and procedure.

Before I describe the specific reforms contained in the Health Security Act, I want to refer to the conclusions of several of the best studies of medical malpractice. Some of these are probably familiar to you, but they are worth repeating. However, I must admit that one of the frustrations about this whole issue is the lack of good empirical data we have to guide our deliberations. For a problem of this importance, the scarcity of reliable research data is astonishing. I am hopeful that we might address the need for top-quality empirical research through this legislation and an increased emphasis on federal funding for such research.

The Harvard Medical Practice Study of hospital discharges in New York in the mid-1980's found that 3.7% of all people discharged from the hospital suffered adverse medical events. Over 25% of those, or 1% of discharges overall, were due to provider negligence.

Only one out of eight patients injured as a result of negligence filed a malpractice claim, and only one out of sixteen received any compensation from the tort system.

In New York, the average delay between initial claim and eventual payment is six years, and over ten years for the more serious injuries.

A different study found that many injured parties are frequently undercompensated, particularly those suffering permanent, serious injuries. Because payment typically comes so long after injury, funds for early rehabilitation are not available.

For every patient who does not receive fair compensation, there is a doctor who feels financially threatened by potential lawsuits, the unpredictability of jury verdicts, and high liability insurance premiums. In one major study, over 80% of patients who filed suits had not in fact been negligently injured. Physicians view the malpractice system as haphazard, unpredictable, and personally traumatic, exposing them to the attendant costs and delays of our troubled civil justice system.

Striking the proper balance of competing concerns in this environment is not an easy task. As the Subcommittees know, having struggled with these issues over the years, there is no simple solution. There are strongly held views on all sides, and some truth on all sides.

The President's proposal provides two new mechanisms for a more sensible and cost-effective approach to resolving medical malpractice disputes. First, it encourages consumers and providers to settle malpractice claims outside of court. Every health plan will be required to develop and have in place at least one alternative dispute resolution mechanism, and every claim against a doctor or other provider must first be referred for alternative dispute resolution before it can be litigated.

While ADR is not binding, meaning that consumers dissatisfied with the outcome can go to court, it is mandatory. Attempting to settle malpractice claims before they get to court has rewards for both patients and providers. Parties suffering real injuries will be compensated sooner and claimants with smaller claims will have increased access to a dispute resolution mechanism. The plan administrators will be aware of those providers with a track record of claims against them, and physicians may be spared the expense and distraction of defending groundless claims.

Second, the Health Security Act provides that the National Practitioner Data Bank will make available to the public the names of practitioners who have a pattern of malpractice payouts or sanctions. As the Subcommittees are aware, under the Health Care Quality Improvement Act, malpractice payouts and sanctions are reported to the National Practitioner Data Bank and are made

available to states or accrediting bodies, but not to the general public.

For the first time, the names of licensed health care practitioners with repeated numbers of malpractice payments or sanctions will be available to the public. Combined with the quality measures in the proposal, the public can make more informed choices about the practitioners they choose. With adequate information, consumers can improve the quality of the health care they receive by their choice of practitioners.

The Health Security Act also contains certain proposed reforms to discourage the filing of frivolous lawsuits and to provide fair, uniform national rules for malpractice awards.

First, the proposed Act limits the amount of a lawyer's fee to no more than one-third of the amount recovered in a malpractice case. However, states may impose lower limits. While some have challenged this proposal as unfair to plaintiffs' trial lawyers, it is a change which has already been implemented in some form in the majority of states. In fact, the Federal Tort Claims Act, under which medical malpractice suits are brought against federally-employed health care providers, establishes even lower attorneys' fee limits.

Second, under the Administration's proposal, before a lawyer can file a medical malpractice lawsuit, he or she has to first consult a qualified medical specialist, and prepare an affidavit including a written report by the medical specialist. The written report must contain the specialist's determination that the specialist has reviewed the medical records, and believes there is a "reasonable and meritorious" claim. Courts can impose sanctions against a plaintiff or attorney for affidavits submitted without reasonable cause.

Third, double recoveries are eliminated by abolishing the collateral source rule in both federal and state medical malpractice cases. The proposal reduces the amount of recovery by any amount recovered from another source, such as private disability insurance. Again, this is simple fairness. If a health plan already provides for the health coverage needed by an injured patient, there is no reason that a malpractice award should include this amount.

Fourth, the proposal allows either party to request that an award be paid periodically rather than in a lump sum. The judge would determine the schedule based on the needs of the injured party. This proposal, which is consistent with the recommendations of the National Conference of Commissioners on Uniform State Laws, is important for both injured parties and

defendants so that damages will compensate people at the time they need the money.

Over the past months, we have examined many different options. I know that distinguished Members of both Subcommittees have put forth different ways of addressing the same problems we have identified. We are here today to discuss how best to accomplish our common goal.

One of the issues that has been debated is consideration of caps on damages in malpractice cases. Many urge that a limit be placed on non-economic damages, such as pain and suffering.

We have examined that issue in detail, and heard every opinion. It was decided not to recommend caps on damages, and let me explain briefly why that decision was made. First, we have designed a series of changes intended to address specific problems with the malpractice system. If we address the problems of frivolous lawsuits and the lack of effective quality measures, and if we place limits on double recoveries, there is no reason to place arbitrary limits on damages.

Second, as I mentioned earlier, studies have shown, and it is obvious, that those affected by caps on damages are those most severely injured who are likely to get large awards. It is those same individuals who need the money to allow them to get on with

their lives. No one wants to tell persons who have been severely injured through the negligence of others that they will not get compensation because there is an arbitrary limit, and that they are simply out of luck.

Third, the states have enacted various limits on damages. It would disrupt those state initiatives to impose limits at the federal level. The state limits vary widely. For example, California has a cap on non-economic damages of \$250,000; Indiana has an overall limit of \$750,000 for all damages.

The Health Security Act attempts to strike a balance between the needs of those who are injured and those working diligently to provide high quality health care. We believe we have done that. We recognize that this is a controversial area, with strongly held views on all sides.

Let me also add that the problems of the medical malpractice system are exemplary of the many difficulties confronting our civil justice system at both the state and federal levels. The Justice Department has undertaken a major access to justice study, aimed at reducing the costs and delays of civil litigation, increasing access to our justice system for all litigants, and restoring public confidence in a system which is fundamental to our concepts of law and liberty. I am hopeful that we can formulate proposals that will address the problems inherent in medical malpractice and other kinds of civil litigation.

I appreciate the opportunity to discuss our views and I look forward to working with all of the Members of these Subcommittees in the months ahead as we move forward in our historic effort to guarantee health security for all Americans.

Mrs. COLLINS. Dr. Clinton, were you prepared to make a statement?

Mr. CLINTON. I have no further statement. We worked collaboratively with the Department of Justice on this statement.

Mrs. COLLINS. OK. Thank you very much.

Mr. Hubbell, my question—let me make sure we got this thing right this time.

The question is why did the bill choose to direct health plans to establish the alternative dispute resolution mechanisms rather than to have them be placed in an impartial setting, perhaps with court supervision?

Mr. HUBBELL. The thought was that we would use alternative dispute resolution as a first step and would give people an opportunity to present claims that may not be brought. The evidence is that one out of eight claims—only one of eight valid claims is usually brought. This will provide a cheaper alternative for valid claims, yet at the same time discourage people later on from bringing bigger claims.

Mrs. COLLINS. In one place the bill actually limits the amount that a plaintiff's attorney can receive on a contingency fee basis. In the bill's pilot program involving practice guidelines, it says that a provider's conformance with the practice guidelines would be a complete defense.

Shouldn't these two provisions cut both ways? That is, shouldn't there be comparable limits on compensation for defense lawyers, and shouldn't deviation from the practice guidelines under the pilot program constitute absolute liability?

Mr. HUBBELL. Those are both very good questions. I think it would be very, very difficult to restrict defense lawyer's fees as a contractual matter between them and the insurance company that would be providing the malpractice defense.

I am sorry. You will have to repeat the second part of your question, Madam Chairwoman.

Mrs. COLLINS. Well, I said it seems like these guidelines ought to cut both ways, you know. And I guess the question was shouldn't there be comparable limits on compensation for defense lawyers, which you have already said, and shouldn't deviation from the practice guidelines under the pilot program constitute absolute liability?

Mr. HUBBELL. I can only speak for myself, and certainly Dr. Clinton is more familiar with the pilot programs, but there sometimes may be reasons for deviations from standard guidelines that could be explained and would not necessarily be negligent. But maybe Dr. Clinton would like to further address that.

Mrs. COLLINS. Would you please, Dr. Clinton?

Mr. CLINTON. Madam Chairwoman, the proposed Act states that this pilot program would determine the effect of applying practice guidelines in the resolution of liability actions. I think the thought there is there are many issues that may be tested, may be examined more completely, and that is the purpose of the pilot project.

So it is not a foregone conclusion that these would be absolute events or would provide evidence that could be submitted to the court without the usual hearsay standards that have been used in

the past. So it is exploratory to examine the sort of questions that you have raised.

Mrs. COLLINS. The bill's provision on periodic payments of awards provides no minimum threshold for the provision to apply, and it doesn't make any distinction between damages that have already accrued and future losses due to the injury.

The question would be, shouldn't the periodic payment provision not apply to damages which have already accrued? That is one part of the question. The second part is shouldn't the bill address situations where the defendant who is making periodic payments becomes insolvent over the time, dies or otherwise fails to make payments? What is going to happen if it is not addressed in the bill, which it isn't as far as I can see?

Mr. HUBBELL. As I believe the bill is written, it gives the judge discretion, if either party asks, to grant periodic payments. I would expect that the judge would normally not grant periodic payments for damages that have already accrued but look to those future payments. In most periodic payment situations, there are usually provisions made to insure against insolvency.

Mrs. COLLINS. So, then the judge in fact has that flexibility?

Mr. HUBBELL. Yes, I believe he or she does.

Mrs. COLLINS. During the spring there were discussions about establishing enterprise liability, which I have talked about a little bit. Why was that option down-scaled to a voluntary demonstration project, Dr. Clinton?

Mr. CLINTON. I think, in essence, Madam Chairwoman, the discussions concluded that it had significant merit and yet it had been untested except on a few occasions, and rather than make a judgment based on such limited factual information, the thought would be, let's try it out.

What we are trying to do in the area of medical liability is understand more completely what works best. Therefore, the President elected to examine demonstration projects with regard to enterprise liability and see if it does bring as much promise as some people believe.

Mrs. COLLINS. Mr. Waxman?

Mr. WAXMAN. On that last point, are you saying that the administration is proposing to try out the enterprise liability notion on a demonstration basis to see if it works?

Mr. CLINTON. Correct.

Mr. WAXMAN. I see. So how would that be formulated? There would be some areas of the country where they would try enterprise liability to replace an individual physician tort liability?

Mr. CLINTON. Correct. Usually that is done in the form of an announcement to States, encouraging them to apply some degree of competition, usually a cooperative agreement with the Federal Government, so that we can work collectively to be sure that we examine the base upon which they are working, have the data collection process that is adequate, and know what we are going to measure.

One of the difficulties with medical liability is what are we trying to measure? It is beyond quality itself. Is it the price of premiums? Is it the number of claims? Is it the number of claims with merit? All that would be worked through in a cooperative project.

Mr. WAXMAN. Is that the reason the administration, which at least in the early days talked about recommending enterprise liability, dropped it from an across-the-board proposal to simply a demonstration to find out more information about it?

Mr. CLINTON. I think it was that there wasn't sufficient evidence to answer the questions that you have raised. It is the reason, however, that we have talked for a number of years about the need for demonstration projects, not necessarily demonstration, but good evaluation of the many liability reform activities that are going on in these States.

Mr. WAXMAN. I have been involved in looking at this area for many, many, I have to say decades, and one of the many frustrations is that we don't really have good data on the connection between medical malpractice liability laws and good medical care. There is little data on the connection between tort laws and defensive medicine. And we know there has got to be some connection but we really can't pin it down.

In my own State of California, for example, that has some very strong tort laws, most of which came about as a result of a recommendation that a committee I chaired in the State legislature proposed, we have those tort laws in effect but we really know of no evidence or very little evidence of the defensive medicine, as we would understand it, having decreased as a result of those tight tort laws, including caps.

We do see that the premium costs have been stabilized and that was worthwhile. But in terms of the big problem on health care, which is defensive medicine, we don't see any evidence that there is any change in the practice of defensive medicine.

Do you have any data on it?

Mr. CLINTON. No. I would concur with your judgment. We have a modest portfolio of medical liability research activities under AHCPR and it doesn't resolve many of the questions you raised.

I think that we know more now than we did 5 years ago, but it doesn't get close to what we really need to know to put together a national plan.

Similarly, a lot of our studies have looked at the patient-provider quality interface, and I think there is more work that needs to be done on the legal processes or the legal services aspect of this, since it is a very complex issue that moves from medicine into the court. And we would argue that more needs to be done in terms of evaluation of what is going on at the present time.

Mr. WAXMAN. I am encouraged at the idea of practice patterns being developed for a lot of different reasons, but so that we also can measure what is appropriate care. But it strikes me that if we put in caps on settlements and decisions for plaintiffs that what that does is discourages lawyers from taking the cases because they won't see the big recovery.

I think lawyers don't take cases where it is questionable whether they can recover at all. I think lawyers take a very narrow spectrum of the cases and then really go for everything they can get. But there are lots of other people who have suffered from medical malpractice who never get any redress of their grievances.

That kind of system seems to me to be wrong, and when I hear the idea that we would say that plaintiffs should be able to—a de-

fendant should be able to recover attorney's fees from plaintiffs, that would further discourage people from ever going into court.

I don't think discouraging people from ever getting compensated for the wrongs done them is a goal that we ought to pursue. What we need to do is to figure out how to change these patterns that give a clear incentive for wasteful medical practices known as defensive medicine, and I would say in my view it is very hard to quite determine how to do it.

I think a number of the proposals the administration is recommending is very constructive, like the certificate of merit and encouraging alternative disputes.

Thank you.

Mrs. COLLINS. Mr. Bliley?

Mr. BLILEY. Thank you, Madam Chairwoman.

Mr. Hubbell, the underlying issue in the medical malpractice debate is the issue of defensive medicine. Many physicians argue, I believe accurately, that the current malpractice system encourages the practice of defensive medicine or the use by physicians of unnecessary and costly tests and procedures to protect against future malpractice claims.

For example, as early as 1969, a leading official of the then U.S. Department of Health, Education and Welfare testified before Congress and said, "We believe that the additional procedures being ordered to minimize the chance of suit are adding significantly to the overall cost of medical care."

Now, Mr. Hubbell, the issue of defensive medicine centers on the fact that physicians and hospitals have been forced to practice medicine to avoid the cost, disruption and discomfort of being sued. Clearly, doctors and hospitals believe that excessive litigation and judicial interference are disrupting the practice of medicine. In fact, on more than one occasion I have had respected surgeons tell me that they were giving up the day-to-day practice of clinical medicine because of the excessive drumbeat of malpractice lawyers.

Although the administration's bill makes some minor improvements in our medical malpractice system, it may actually encourage more administrative procedures and litigation because the alternative dispute resolution system is nonbinding. If a plaintiff is dissatisfied with the ADR result, they simply go directly to court. Under the administration's proposal, plaintiff attorneys will use ADR as an elaborate discovery proceeding.

Now, Mr. Hubbell, I would like to turn your attention to sections 5233 through 5243 of the bill, beginning on page 906.

Mr. HUBBELL. I do not have page 906. Are you talking about the remedies section, Congressman?

Mr. BLILEY. I am talking about the sections that create a new series of private rights of action to enforce the health care entitlements of the bill.

Mr. HUBBELL. I am not fully familiar with those sections which are not part of the malpractice proposals. We have a group at Justice who are working on the remedies sections of the bill, but I did not bring those sections with me, Congressman.

Mr. BLILEY. Well, one of the—section 5235 confers a private cause of action against States to enforce State responsibilities. Section 5236 confers an enforceable right of action on any person to

sue the Secretary of HHS to enforce Federal responsibilities. And section 5237 confers a private cause of action on individuals to sue the Alliances.

I believe that the creation of these and other new Federal rights of action in the administration's bill will lead to a new stampede to the Federal courts by lawyers suing on the enforcement of every new Federal, State and Alliance duty specified in the statute.

It will ultimately add new meaning to the term "defensive medicine." Not only will providers be looking over their shoulders concerning malpractice, but they will also have to worry about these new types of Federal lawsuits.

Would you like to comment on that?

Mr. HUBBELL. Again, on the remedies section, which is not the malpractice section, we have those provisions under review, and I know that Professor Dellenger would be happy to address those in another hearing, because we are working on those.

I don't believe necessarily though that they affect malpractice. It does not create a private right of cause of action other than what an individual already has to bring a case against a provider for malpractice.

Mr. BLILEY. Well, one of our witnesses, Dr. Green, will testify later today that 12.3 percent of OB-GYN's have quit obstetrics and almost one-quarter have decreased the amount of high-risk obstetric care they provide because of malpractice.

His statement also notes that in New York City 90 percent of the OB-GYN's have been sued, with an average number of four suits against them.

As I noted in my opening statement, access to insurance does not necessarily lead to a guarantee of access to care, and I am concerned that the enactment of the President's plan would not resolve access problems of this nature.

Could you walk us through the administration's malpractice provisions and tell us how each would alleviate this situation?

Mr. HUBBELL. Yes. In addition to the demonstration projects, before an individual could bring a malpractice action first that individual would have to go through a mandatory ADR process that would be created by the respective Alliance. Then if that person is dissatisfied with the ADR process, he or she is required to get a certificate of merit, which would require an affidavit explaining the reasons for the malpractice, before a suit could be initiated.

We believe that requirement will assist in preventing those cases that should not be brought from being brought.

Mr. BLILEY. Thank you. Thank you, Madam Chairwoman.

Mrs. COLLINS. Dr. Rowland?

Mr. ROWLAND. Thank you, Madam Chairwoman.

It is always interesting to listen to the debate on whether or not defensive medicine contributes to the cost of—the increasing cost of medical care, and we don't seem to be able to have any statistics to prove that, but in fact I believe it is a driving force in the cost of medical care. I really believe it has a lot to do with OB doctors no longer being in rural areas. That they have left rural areas because of that.

I was talking with a friend week before last who is a radiologist, hospital-based radiologist in my hometown of Dublin, Ga, and he

said that 50 percent of the studies that he does in that radiology department are done because of a fear of malpractice. And it is just strange to me that we are not able to get any statistics, but you hear this sort of thing repeatedly.

But let me ask you something. Since States have different standards for malpractice, how would this be resolved under the new reforms if you establish an alternative dispute resolution mechanism?

Mr. HUBBELL. Well, for those States, unless they are in a demonstration project State, those standards would still be State by State for malpractice. Now, I wasn't aware that there is much inconsistency in the standards. It is usually a standard of care based on the community standard.

Mr. ROWLAND. Well, there would be some variation in the way that these ADR's would work then?

Mr. HUBBELL. Yes.

Mr. ROWLAND. I see. If a person was not satisfied with the resolution in an ADR, would they go to State court or Federal court? How would that be resolved?

Mr. HUBBELL. Normally, after they received a certificate of merit, which is another requirement before they could institute a lawsuit, then they—normally, I would expect they would go to State court, unless there was some kind of diversity of them and complaints of damage that would meet the diversity.

Mr. ROWLAND. How would that determination be made as to whether or not they go to each court? That is not exactly clear to me.

Mr. HUBBELL. Normally, they would be brought in State court, unless there was some case where there was a diversity of citizenship, if you could get in Federal court under diversity of citizenship, which would not be the normal case in a medical malpractice case.

Mr. ROWLAND. I see. How would the new reforms affect the Federal Tort Claims Act?

Mr. HUBBELL. It would not affect that. There are still limitations in the Federal Torts Claims Act on attorney's fees, for example.

Mr. ROWLAND. Can you sort of give me a general statement about what the malpractice reform in the Clinton initiative would do? Sort of general statement on that, compared to what we have in place now?

Mr. HUBBELL. Well, I think first of all we have the ADR mechanism, which is new, which is mandatory. Then we have the requirement of a certificate of merit. Then we have a limit on attorney's fees.

Then we have the requirement that the names of repeat offenders would be published through the National Data Bank. And another major item is the mandatory reduction of any malpractice award by collateral sources. And then we have the periodic payment of awards.

Mr. ROWLAND. I am sure you must be familiar with other malpractice proposals. Is there any common thread that you find among any of the proposals that you know about?

Mr. HUBBELL. I think that one of the most common threads is the alternative dispute resolution before the institution of a suit.

Another is the requirement that there be some preliminary review by a physician before a lawsuit is brought. That is contained in our certificate of merit.

There now are in most States some consideration of limits on attorney's fees and something to do with—there are several States that do have caps on noneconomic award.

Mr. ROWLAND. Do you anticipate much opposition to these?

Mr. HUBBELL. Yes. Well, I see it from both sides, Congressman. I see on one side people wanting to make ADR mandatory—think that ADR should be mandatory, that there be a greater limit on attorney's fees, and that there be a cap on noneconomic damage.

And from the other side I would see an argument that this is not needed, there isn't any empirical data to support it, and that there shouldn't be a restriction on the right to go in court.

Mr. ROWLAND. You know, I think about the statistics or empirical data that will prove this thing or that thing, and I guess you can take numbers and prove or disprove most anything that you want to. I recall having Chairman Waxman come down to my State of Georgia to talk about physicians who were going to stop their Medicare. No data to substantiate that, but in fact there are numerous physicians now who are not taking Medicare patients anymore because they don't find it to be in their best interest.

Thank you.

Mrs. COLLINS. Mr. Stearns?

Mr. STEARNS. Thank you, Madam Chairwoman.

Mr. Hubbell, I was listening to Mr. Bliley's question, and I think he asked you a question and to my mind you didn't quite answer it. The point of his question was that there is new Federal rights of action. He listed all of those, suing the Alliance.

And we believe that a new flood of Federal lawsuits in addition to malpractice could occur. From a physician's point of view, a lawsuit is a lawsuit. Would you like to answer Mr. Bliley's question?

Mr. HUBBELL. Well, I think Mr. Bliley—

Mr. STEARNS. And I might point out now if the alliance is sued the taxpayers are going to have to fund this. So, if we open up a whole new flood of lawsuits on the Alliances and all these things that Mr. Bliley talked about, ultimately the taxpayers are going to have to pay for all these. Don't you agree?

Mr. HUBBELL. Well, first of all, I don't necessarily agree that we will be opening up a new flood of lawsuits. Obviously, this health security plan is a major reform in health care, and to the extent that we don't have Alliances right now, certainly that there has to be some remedies that people will have available to them if they don't comply with the law that this Congress, hopefully, will enact. So I don't see it opening up a flood of new lawsuits.

But you do have to give citizens—and again we are working on the remedies section, which is not a part of the malpractice section. You do have to give private citizens and others the right if an Alliance fails to comply with the law to force the Alliance to comply with the law. We don't necessarily see a flood of new lawsuits or that it would affect the physicians themselves.

Mr. STEARNS. Well, I think both of us would agree it provides a new set of Federal rights, and what I have seen in past experience

as a small businessman a new set of Federal rights mean a new set of possibilities.

Let me move on to the next question I have. You note in your testimony that it was decided not to recommend caps on damages, because if frivolous lawsuits and double recoveries were eliminated then there would be no reason to place limits on damages.

However, it is a potential for multi-million dollar lawsuits which drive the cost of medical malpractice insurance through the roof as insurance companies must factor in that very potential into all their costs. Caps on non economic damages would in no way limit the amount of money that an injured plaintiff could receive to cover his hospital cost, doctor bills and other medical expenses.

No other country in the world awards noneconomic damages at or even near the level of such awards in the United States. For example, noneconomic damages awards in Sweden are only one-tenth of the U.S. awards, and Canada imposes a \$180,000 cap on pain and suffering awards.

Moreover, a \$250,000 cap on noneconomic damages would affect very few claimants. The General Accounting Office found that in 1984 just 2 percent of medical liability cases nationwide produce noneconomic awards of over 200,000. Yet this 2 percent accounted for over 60 percent of the total noneconomic payouts. Therefore a cap would produce significant savings without affecting many claimants.

Mr. Hubbell, how can you not consider capping noneconomic damages under these circumstances, this data?

Mr. HUBBELL. Well, I am not familiar with the data you have. I think that we do not have data where you have a system where there is an elimination or a reduction of the awards by collateral sources. In the malpractice awards that I am familiar with, usually the largest amount of those awards is not noneconomic. It deals with future earnings and things of that sort.

It is a balancing. But, if you are now going to establish a system where you do not—you reduce the awards by all collateral sources, which I think will substantially reduce the number of—the dollar amount of the awards, then we should look at—if indeed there is a case where there is significant pain and suffering, we shouldn't necessarily limit it without any data under the new system. And so we have tried to strike that balance.

Mr. STEARNS. I just might point out I heard Mr. Waxman's question about California. Do you believe in uniformity across the Nation in terms of this or should each State differ?

Mr. HUBBELL. We have tried to establish a system where each State will have the ability to deal with it on a State by State basis. So I am not—under the plan in general we do have State-run Alliances.

Mr. STEARNS. Well, the President's reform bill limits attorney's contingency fees to one-third. You note in your testimony that this is a change which has already been implemented in the majority of the States and that States may impose lower limits.

Would you consider further limits to attorney fees, perhaps on a sliding scale?

Mr. HUBBELL. I know that that has been discussed and considered, and, again, in trying to balance the various aspects of the bill

we felt that a third was appropriate for a national standard with allowing States to go lower. Again, we are looking at a different type of award than we would normally look at under the current system with the reduction under the collateral source rule.

Mr. STEARNS. Thank you, Madam Chairwoman.

Mrs. COLLINS. Mr. Brown?

Mr. BROWN. Thank you, Madam Chairwoman.

Dr. Clinton, I would like to ask you about the National Practitioner Data Bank. Some claim that releasing this information to the public will result in more frivolous or nonmeritorious lawsuits, if you will. It seems that that is based on—it seems the problem in my mind, and correct me to make sure I understand this, that when these were created, the National Practitioner Data Bank was created some 4 or so years ago, that the information is available to physicians about themselves, to accreditation boards to make decisions about physicians, to hospitals that are about to bring a physician on staff. Correct?

Mr. CLINTON. Correct.

Mr. BROWN. The information is confined, by and large, to resolution of malpractice cases, either a verdict or to a settlement.

Mr. CLINTON. If there was an award.

Mr. BROWN. If there is an award, right.

Mr. CLINTON. Right. There are two other areas, disciplinary actions by a State Medical Board or a professional board, and limitations of practices. Those also are added to the Data Bank.

Mr. BROWN. Now, the opponents, though, it is my understanding, Dr. Clinton, is the opponents to opening this bank up to the public believe that less than scrupulous patients or lawyers might use this to—it might encourage them to file lawsuits. Correct? Is that what they are pretty much saying?

Mr. CLINTON. I think there are several statements. Perhaps the overriding one is that since this is fairly minimal information—simply that a clinician was involved with an award, whether it had merit and the circumstances of the case are not in great detail—that the public cannot make much of a judgment about that piece of information, and therefore it is sort of incomplete information for the average citizen.

Now, indeed others would argue that it could be misused. Someone might be looking for any physician who was—because he deals with high risk cases or cancer cases or complex surgical cases—that physician might be the subject of someone searching him out to see if we can find a case. Since he has already been in the bank, maybe we can get him again.

So all those things are talked about on the street. It is a question of whether the information is adequate for making any kind of decision on the part of the public, on the part of the citizen for either joining a plan or joining a clinician in the plan.

Mr. BROWN. So isn't the answer—if that criticism—the critics of opening up the Data Bank, if that has any validity, isn't the answer twofold? One is that the problem of incomplete information is temporal in a sense. It is that this Data Bank has only been gathering information for 2 or 3 years, so you don't know what happened, what this physician did in the 1970's and 1980's. You don't

even know what happened to her or him in the last 2 or 3 or 4 years.

Mr. CLINTON. Correct.

Mr. BROWN. And so that temporal problem, if you will, will take care of itself over time as the Data Bank ages, if you will.

Mr. CLINTON. Correct.

Mr. BROWN. The other is too little detail on the malpractice settlement, the verdict or the settlement, perhaps too little detail on any limitation of practice, any disciplinary action. Why then with the Health Security Act providing sort of the—the release of the information, why don't you enlarge the scope of the information? Why isn't that part of the proposal, to enlarge the scope of the information in the Data Bank anyway?

Mr. CLINTON. That is a separate piece of legislation. The Department has followed the National Practitioner Data Bank rules as established in the Act rather precisely. There was not the intent at that time to add additional information.

Recall the purpose of the bank was to avoid instances in which practitioners had restrictions of privileges or awards made against them and they skipped to another jurisdiction, got a license and the new jurisdiction was not aware of it. That was its primary purpose.

Now, some want to use the Bank for additional purposes, but I think we always have to return to the legislative intent as it was established in 1986.

On the other side, if the public believes that the information is at least a signal about an event, then from that standpoint it is "let the buyer beware." So providing the information under some circumstances, that is to say, the Department would determine which circumstances are reported for repeat offenders, and allowing the public to make a judgment about that and to pursue it. But finding out the details is to some extent possible.

Mr. BROWN. But the public makes a better decision if there is more information.

Mr. CLINTON. Correct.

Mr. BROWN. So do you advocate sort of an enlargement or an expansion of the amount of information that a physician—excuse me, Madam Chairwoman—of the physician having to provide or the disciplinary board or whatever having to provide a little fuller, more full disclosure.

Mr. CLINTON. There is a slight improvement in that, a practitioner can provide a very brief statement, I think it is limited to 600 characters, to make a statement with regard to the particular action for which that person is in the Bank. So it does provide some element of clarification. Department of Defense and the Veterans Administration has followed that from the very beginning, trying of provide a bit more information so it can clarify why that entry is there.

Mrs. COLLINS. The time of the gentleman has expired.

Mr. BROWN. Thank you, Madam Chairwoman.

Mrs. COLLINS. Mr. Klug?

Mr. KLUG. Actually, I am going to keep following up on this same line of questioning that Mr. Brown just brought up, and my preju-

dice is obvious in this. I used to be a former journalist. So the more public records the better from my perspective.

Is it clear that—you know, the earlier testimony made it very clear that the administration wanted to see all these records released. Is that now what is actually in the legislation itself or what we will finally see in the legislation?

Mr. CLINTON. The legislation will state that the Department would establish rules for public access and the Secretary would be required to establish the rules that surround that. Whether that is—it talks about repeat offenders—and we would have to make a determination of what that means. I think we ought to do some analysis of the data to know how many repeat offenders are in it, whether that encompasses 90 percent or whether that encompasses a smaller percent.

Mr. KLUG. Repeat offenders in terms—

Mr. CLINTON. I think clearly from what we have heard, most OBGYN specialists are going to be repeat offenders because that is where litigation has been very high. Surgeons across the board are going to be in there on repeated instances because that is where the majority of malpractice events have occurred in the past. Family physicians, if they don't deliver babies probably are not going to be in there very often. If they do, they will.

Mr. KLUG. Now, the Data Bank that you have, if you analyze that, how many of the disciplinary actions, if you will, are State disciplinary actions versus malpractice suits versus hospital privileges?

Mr. CLINTON. Oh, the great majority are malpractice awards. Great majority.

Mr. KLUG. Now, one of the areas, I know, of concern at this point has been the whole area of clinical privileges. That if there has been an area where the data has been incomplete or have been challenged that has certainly been the one point.

Have you figured out a way to tighten up the guidelines? Because if we get into a situation where we want to force the release of records, I suspect this is where we are going to have the toughest fights over it. Any thoughts on that?

Mr. CLINTON. Not at the moment. I think that is a real challenge. Since that is determined at the local hospital entity, I don't think we know enough to say that there should be a national standard for that.

Mr. KLUG. A national standard for reporting it or a national standard for how you evaluate it?

Mr. CLINTON. Defining it, since it is usually done by the clinicians in that hospital and they decide whether an individual has the experience, training, and demonstrated expertise to take on a particular function, or whether they went beyond what they should have done, or should have some restrictions on their clinical privileges. For example doing a certain kind of surgical intervention, for example, alone.

Mr. KLUG. So, as you look forward to trying to draft regulations or draft standards of what should be released and should not be released, can you give me an idea of where your thoughts are at this point?

Mr. CLINTON. The intent is that the National Practitioner Data Bank would establish a rule by which the public could gain access to the data in the National Practitioner Bank on repeat offenders. And as I say, the debate has not settled with regard to what repeat means, probably a few. We need to look at the data, examine it more completely to determine what that might be.

One entry, perhaps, would not be reported to the public. More than one, that is the essence of the debate.

Mr. KLUG. Now, that seems to me to be a reasonable standard for malpractice cases. It may not be a reasonable standard for disciplinary actions taken by a State. If you lose your license once, it seems to me you have lost your license and the public should be aware of that.

Mr. CLINTON. That is a good point.

Mr. KLUG. And you agree?

Mr. CLINTON. I agree that it ought to be discussed more completely. And I think the President has said in the beginning this is the framework, some of the sentences deserve more discussion, and we will certainly take that into consideration.

Mr. KLUG. Now, one of the normal exemptions under the freedom of information act are privacy concerns, and obviously that involves records. We can see much of what the Navy has, can't see national security issues and can't see privacy records. Not that it is embarrassing to a physician, but in the sense that you don't want everybody to have access to everybody's medical records. How are you going to balance that need?

Mr. CLINTON. I know that the National Practitioner Data Bank enjoys certain protections under the Freedom of Information, and I am not aware that there is any intent to change that protection. I think that would require a change in the Freedom of Information Act as much as it would the National Practitioner Data Bank Act.

Mr. KLUG. What information would you normally receive, for example, in a malpractice case? What do you know?

Mr. CLINTON. It is specified in the law, and the Bank has stayed right within the parameters established in the Health Care Quality Improvement Act. It is the event, and the award, and the physicians involved, and the institution where the event occurred. It is about as limited as that.

Mr. KLUG. And who passes that on to you?

Mr. CLINTON. That information is provided to the bank by the entity that made the payment.

Mr. KLUG. Thanks. I yield back my time.

Mrs. COLLINS. I thank the gentleman for yielding back his time.

Mr. Franks?

Mr. FRANKS. Thank you, Madam Chairwoman. I will try to be rather quick, since we do have a vote going on at this time.

One of the positives of having caps on claims would be to help control costs. So, why would you, Mr. Hubbell, and Dr. Clinton, be opposed to such a measure?

And also, the losing side paying the other's legal expenses seems like a prudent way of eliminating frivolous lawsuits, and that too would allow for us to control costs. Why would you be against that as well?

Mr. HUBBELL. First, with regard to caps on claims, we are talking about developing a new system where in the past there could be potential for double recoveries, the collateral source rule, and as we modify the system to do away with the collateral source rule, the question is whether it is then necessary or appropriate to put an arbitrary cap on pain and suffering or mental anguish or to leave that to the discretion of a jury, especially after you do away with other collateral source rules which might lead to a more excessive noneconomic award, and see how that system works and believe that that system will work. So that is the reason for what we are proposing here.

Again, as we look at trying to modify the system, we are looking at not placing a cap because we are making modifications in another area.

Mr. FRANKS. On the other side paying? The losing side paying the—

Mr. HUBBELL. On the other side losing, that has been an ongoing debate for a long time. In reality, many, many people, the only access they have to the court system is through the contingency fee system, and awarding a large amount for defense if they bring a case will in most cases probably will end up being a noncollectible judgment anyway. So we don't see that as a real effect. It might, in fact, deter bringing valid claims.

Mr. FRANKS. Madam Chairwoman, I yield back the balance of my time.

Mrs. COLLINS. Thank you very much.

We have a vote on the floor of the House of Representatives, so we are going to take a recess for 5 or 10 minutes. Then we will come right back.

[Brief recess].

Mrs. COLLINS. This joint hearing of the Subcommittee on Commerce, Consumer Protection and Competitiveness and the Subcommittee on Health and the Environment will reconvene at this point in time.

When we left we were just getting ready to recognize the gentleman from Tennessee, Mr. Cooper.

Mr. Cooper?

Mr. COOPER. Thank you, Madam Chairwoman. I appreciate your holding the hearing, so that I could ask a couple of questions.

I support the administration's effort to include malpractice reform in the health care bill. This could be one of the most emotional and toughest issues to resolve.

We have been grappling with the issue of scorability, and I was wondering is the administration assuming any budget savings from the malpractice sections in their bill?

Mr. HUBBELL. I really don't know the answer to that, but I would anticipate that clearly it would involve savings, especially the collateral source provisions of the bill would be, I think, not only a tremendous savings, but a tremendous advantage to the malpractice insurers and underwriting, and I would hope that all of this would be passed back to the consumer.

Mr. COOPER. Of course, the various medical societies have claimed that defensive medicine costs, you know, may be tens of billions of dollars a year, and it would be wonderful to get that

waste out of the system. And, of course, the real goal is to pass that saving along to the consumer, to the patient.

Mr. HUBBELL. Correct.

Mr. COOPER. And that is even harder to score, as I understand it.

Is there any way to make sure that consumers or patients benefit as we try to lower the cost of defensive medicine?

Mr. HUBBELL. I don't know the ways to insure it. I am not that familiar with this book yet. I am learning.

But certainly, especially in the areas of hospital insurance where clearly we will be able to know what the reduction in costs are through your State Insurance Commissioners, where you are able to know where the reductions in malpractice premiums are.

Hopefully, we can be able to know very clearly where they are in the malpractice premiums. I think the unknown at this point is in the defensive medicine and how we can score that. But, if you believe almost every physician you talk to, those savings will be substantial.

Mr. COOPER. That is one of the interesting issues. Individual physicians tell you that the savings will be substantial, but informally I have been talking with a number of the medical societies and they admit to me privately that we could pass the statute of their dreams and they would lower bills to patients by less than 1 percent. It would reduce unnecessary testing by less than 1 percent.

In fact, one of the more honest spokespersons told me that it would take a generation of doctors to die off before they would really change practice behavior, because once you learn something and learn it well, and you have been taught to disregard cost, and you have been taught on a fee-for-service basis in which volume is rewarded, it is awfully hard to teach an old dog new tricks.

Mr. CLINTON. Our job is to train old dogs and new dogs.

I think the statements that were provided to you were probably accurate and from that individual's experience. But I take some issue that we can't find ways to provide more effective treatment and oftentimes save money. Not in great amounts, but by reducing unnecessary tests. And that is the purpose of the clinical practice guideline movement.

We are not here today to talk about that in detail. It is in other parts of the Act. But it does relate to some of the things under medical malpractice.

I think that while there will never be enough clinical practice guidelines done to cover all things, I think in many instances we have through the clinical practice guideline movement demonstrated that many of the diagnostic tests that were done routinely are unnecessary.

I think we can then begin to weed out systematically unnecessary diagnostic and unnecessary, ineffective therapeutic interventions, and that way I think it contributes. And, as that contributes to lowering the cost of treatment, it will contribute to lowering the cost of the premium, and that way it makes its way into the system.

Now, none of us have ever said that this is going to have great, great cost savings. I have never suggested in testimony in the past

that it might do anything other than, perhaps, lower it something in the order of 10 percent.

No one of these things is going to solve the problem. But I think collectively good practice guidelines, we have talked about that here extensively here in the Congress and with the medical specialty societies, good malpractice reform, all those things I think can contribute. More than 1 percent.

Mr. COOPER. I support good practice guidelines. I support malpractice reform. I also support greater cost sensitivity on the part of patients so that they will be more careful in what they demand. I also support some sort of greater awareness that fee-for-service medicine is essentially payment by volume and it encourages even the best providers to do more volume in order to raise their compensation.

So, hopefully, working together we can lower the cost of defensive medicine to pass along real savings to consumers. Because it has been my impression that in the California experience while premiums may have come down, patients have not benefited from that premium reduction.

So this is a vital issue, and unless we solve it and solve it soon, and get a real negotiation here between the trial lawyers and the doctors on what is reasonable and what will benefit patients, we are going to have a real tough time passing anything in this area.

Mrs. COLLINS. Mr. Greenwood?

Mr. GREENWOOD. Thank you, Madam Chairwoman.

Mr. Hubbell, there are a number of bills before the Congress to reform the health care system, and all of them have something in common except the administration's bill. The House Republican bill has a \$250,000 cap on noneconomic damages. The Senate Republican bill has a \$250,000 cap on noneconomic benefits. The bipartisan bill of Mr. Cooper has a \$250,000 cap on noneconomic damages. And even the Breaux bill establishes a commission to look at caps on noneconomic damages. Only the administration's bill is silent on that issue.

People look at that and they wonder why. People say, "Well, the President is a lawyer. The Vice President is a lawyer. You are a lawyer. I think Mr. Paster in the Congressional Liaison's Office is a former lobbyist for the trial lawyers, and on top of that they see the Clinton campaign received something like \$480,000 in its campaign last year from the trial lawyers. One of the biggest campaign contributions to the Clinton campaign."

Why shouldn't people ask the question, Is this administration in the trial lawyer's pockets?

Mr. HUBBELL. Well, I would take issue with that, Congressman, obviously. But I would like to address why we are looking and not placing caps, and there are several reasons.

One, there is a balancing here where we are eliminating from judgments collateral sources. In real life the majority of a major award in a medical malpractice case relates to the medical expenses that have been incurred that may have been recovered from private sources, from loss of—from disability in the future, which in this case may be recovered from other sources, all which reduce the amount of judgment. Those are the major portions of award.

In addition, any State can impose caps, as many have. But we leave to the States that authority. As we go into this new system, the States themselves may choose that they don't believe a cap on economic damages is appropriate—noneconomic damages is appropriate. So we leave to the States that ability.

So, it does not necessarily differ with the other bills, but gives the States discretion. And we are dealing with a new system where all the other systems have the collateral source rule and where those—usually noneconomic damages, in my experience as a lawyer, noneconomic damages are usually a multiplier of what are called specials, that being medical bills and other out-of-pocket expenses. When you eliminate those from the judgment, we are dealing with a new system. And we believe that each State should look at the noneconomic issue on a State basis and not necessarily mandate a cap when it may harm individuals who have suffered greatly in those unique circumstances.

Mr. GREENWOOD. Tell me, if you will, what is the down side of capping noneconomic damages? Why is it that the good minds that have devised these alternative health care reform plans have come to the conclusion that a cap on noneconomic damages is critical to holding down the cost of malpractice insurance?

The administration has not come to that conclusion. What is the down side? What goes wrong if you cap noneconomic damages?

Mr. HUBBELL. Well, there are and will always be individual circumstances where people have suffered far and above those caps, and I am sure you know of those yourself.

Mr. GREENWOOD. Suffered economically or—

Mr. HUBBELL. Noneconomically. I know of circumstances, and that our jury system has been in place for a long time, and although we—again, what I am trying to say is when you are balancing a brand-new system where you eliminate the major factors in an award, and you look at a noneconomic cap and you give the States the authority, State by State, to take a look at that situation, then you are giving more flexibility than putting an arbitrary cap across the country on damage awards. What may seem to be reasonable nationwide may not be reasonable in other areas of the country.

Mr. GREENWOOD. What is an example of someone who would have all of their economic damages compensated as a result of the malpractice suit and not be made whole by virtue of the fact that they don't get these noneconomic damages?

Mr. HUBBELL. Well, you know, I have usually been on the other side, but I certainly know of circumstances where perhaps someone who through medical malpractice—and I hope this never occurs, but it certainly might have—someone suffers severe, severe burn damage to their body, where they suffer for years and years under great, great pain and suffering. There may be those circumstances where a cap would do that person a great disservice.

Mr. GREENWOOD. Thank you.

Mrs. COLLINS. Mr. Moorhead?

Mr. MOORHEAD. Thank you. One thing I have been concerned about is the certificate of merit that is required before bringing an action. Most of us that have tried court cases know that you can get physicians that will come and testify for the defense, those that

will testify for the plaintiff, and they are absolutely contrary in their determination.

If you can just pick out anybody to give you a certificate or to say that there is a meritorious case, how do we know we won't get the same kind of thing we do in the courtroom where you get, obviously, one physician or the other giving a pretty far-stretched opinion as to merit?

Should there not be some kind of a board set up or someplace where professional people that are neutral on the subject, not paid by either side, could make that determination?

Mr. HUBBELL. Well, I think there are plans where there is a board. But in this case, realize that plaintiffs first will have had to go, before the issue of medical specialist comes up, through an alternative dispute resolution system. They will have to have gone through that before they have to then hire a medical specialist and prepare the certificate of merit. So those issues may have been fleshed out through the alternative dispute resolution.

We are adding to that the medical specialist certificate of merit, adding to the alternative dispute resolution a requirement of a certificate from at least one physician who is qualified. And if that person is not qualified, there are sanctions that can be imposed on the lawyer.

Mr. MOORHEAD. It is awfully hard to determine when someone has got a license.

Mr. HUBBELL. Dr. Clinton might want to address it.

Mr. CLINTON. Congressman, I think if you examine the language very carefully, I think the administration has attempted to avoid what has been a problem in the past, and it defines on page 925 the qualified medical specialist: Knowledgeable of and expertise in the same specialty area of medical practice; reason to believe by the individual bringing the action to be knowledgeable on the relevant issues; to have practiced; to have taught; to be qualified by experience and demonstrated competence.

I think that does exclude many of the so-called experts that have plagued this process in the past. This may be expanded upon with some good ideas. But I think the intent here was to get the true specialist who indeed is qualified in that area to make a judgment about the claim.

Mr. MOORHEAD. I am concerned about limits on noneconomic damages, such as many of the other people who have already asked questions have been. You mentioned earlier that you didn't think that loss of wages later on in life was an economic loss. But it definitely is an economic loss and that is one of the controls that people are talking about.

Mr. HUBBELL. Congressman, if I did I was in error. I certainly didn't mean to say that loss of wages was noneconomic.

Mr. MOORHEAD. You listed that as one of the things that would be lost if we had reductions of noneconomic damages.

Mr. HUBBELL. Under certain circumstances, if you have, for example, with your employer a wage continuation plan—OK?—where if you are also disabled and cannot work and you have a plan for wage continuation for a period of 2 or 3 years, which some unions do, the amount that you would receive from that plan would be reduced from a judgment you would receive because we would abolish

the collateral source rule. That is what I meant to say, and I apologize if I was in error.

Mr. MOORHEAD. One thing I am wondering about, we have different standards in different States. Some States have some limitations on judgments. Others do not. But we are trying to impose a nationwide plan of coverage on the American people, and if you have areas where there are tremendous divergences, and yet the economic rewards may be very similar, isn't it going to create an unbalanced system?

Should you not have reasonably the same standard in each State as far as potential recoveries from malpractice cases, the burden it is going to put on the doctors or the hospitals or the services if we have one rule in one area and another rule in another place, and yet the insurance coverage is similar, everything else down the line is similar? Aren't you going to run into a lot of difficulties?

Mr. HUBBELL. Obviously, we haven't put this in place, but the system is designed to run to some extent by States and within the Alliances. Certainly any State can impose those caps if they deem them appropriate.

But, again, when you are balancing and dealing with a new system, and doing away with a historical rule, the collateral source rule, I think there needs to be some examination of whether there is going to be any abuse by not having a cap, at least on a nationwide level.

Mr. MOORHEAD. I see I got the red light here.

Mrs. COLLINS. Mr. Hastert?

Mr. HASTERT. Well, I thank the gentlewoman, the chairwoman from Illinois, who has done a very good job of presiding over this committee. And I appreciate you gentlemen being here today.

I would like to follow up on this a little bit. You know, it seems to me, I guess probably being a trial lawyer in Arkansas I see something from one side of the perspective, being in the State legislature and trying to pass liability reform, and now malpractice reform, in a State legislature is a little different perspective. And to try to get something through a State Judiciary Committee in a State legislature is pretty tough, because the ilk there is all trial lawyers and they have, you know, the built-in lobby.

But I would suggest when you don't have a uniformity standard, a Federal law, and you let States pick and choose or put caps on or not put caps on at their leisure or their own discretion, that you end up having venue shopping, the same type of venue shopping that we have in injury legislation in the Railroad Act all over this country.

And what trial lawyers just do is decide what State they are going to file their law in when they can and they will venue shop and go to that State. So I think you need to have some type of uniformity there, and you might think that through.

The other issue that I—Dr. Clinton, when I was here earlier listening to your testimony, talked about enterprise liability insurance. It seems to me it goes back to the experience that we had in liability reform and the crisis that we had probably in the 1985 and 1986 throughout this Nation, the liability insurance.

Enterprise liability in a sense goes to the deep pockets, and if an enterprise certainly is seen as a conglomeration of people with eco-

conomic interests, then all of a sudden all you do is allow trial lawyers in their quest to go to a deep pocket situation, and I think it becomes even more egregious than you had prior.

So, you know, I would be interested to see how you set up your study on enterprise liability. But I think that certainly as a premise it is flawed to begin with. You know, I think it is interesting to see that the five or six health care bills that are out there really have rejected enterprise liability because of that flaw, and you may look at that and consider it.

Tell me, you know, throughout this process alternative dispute resolutions are something that you adhere to in your plan. Give us a little logic why. Either one.

Mr. HUBBELL. We do adhere to it, although we don't make it binding. Because we believe there are, and there are some empirical data, that a lot of medical malpractice claims are not brought because they are of the smaller type. That people do not bring them because of the size of the case and they can't get attorneys to take them.

And the purpose of ADR in this system is to assist primarily in the area of the people who cannot afford to bring them, and do not have ability to get a lawyer to bring the case and yet have economic loss to some extent and a good claim. And hopefully, those claims can be resolved by ADR.

Mr. HASTERT. Well, I think you will find, and I tend to agree with it, not only that, the ADR does something else too. It expedites the system. We find people who have been floating into the system because of appeals and appeals for 5 or 6 years and not being able to go out and live their life. ADR also sets the—the alternative dispute resolution is resolved and people get what is coming to them, their just compensation, and they can go out and live their life again, and not being strung out in the courts, which is not only very expensive for the system but it takes money out of their pocket as well. So we applaud the ADR.

The only issue that we have gone with in H.R. 3080, which has the most sponsors of any bill in the Congress at this point, about 140 sponsors, is that we also look at saying that if you want to appeal the ADR, then you go back to the English system.

You know, it is kind of the certificate situation that you talk about too. That there is some consequence. If you don't get over—an increased award or justified increase, then you end up facing the cost of that procedure as well.

And, you know, the difference in our bill and your bill is basically a difference in the limits on awards for attorneys. You are about 33 percent, I think, which is what the standard practice is now. We are a little bit less than that. So I think there is some commonality.

I think we need to continue to work on that commonality. Because, you know, contrary to what the testimony was here, I think it does drive—defensive medicine drives costs, and you need to find ways to hold those costs down. In any other industrialized nation that you go to, if you go look at the Canadian system, they laugh. I mean they have a single-payer system, but they say their system wouldn't work if we have the medical liability laws in Canada that

we have in this country. They just don't exist as we see them today.

So, I appreciate your testimony. Thank you for being here.

And, Madam Chairwoman, I appreciate your leadership here.

Mrs. COLLINS. Thank you.

Mr. McMillan?

Mr. MCMILLAN. Thank you, Madam Chairwoman.

I apologize for missing your testimony. I had to go to a Budget Committee hearing where we talked about some of these issues, financial ramifications.

I believe, Mr. Hubbell, that one problem of expecting the States to address their own limitations on noneconomic damages is that—one problem is that some States—Texas, Kentucky, Arizona, I think—cannot constitutionally pass such limitations, and yet this problem has a direct effect on Federal programs. The aggregate cost of Medicare and Medicaid is well in excess of \$200 billion a year.

If, in fact, defensive health care costs are, Dr. Clinton, 10 percent of health care costs, then we are talking about \$90 billion. That is enough money to pick up the cost of the uninsured in this country at a time that we are struggling to try to find the means to do that. So I think that is one argument for it.

I am sensitive to what you say about those unusual situations in which economic damages don't fully measure the problem, but I do think that it is one that is much abused, and perhaps there is some vehicle that can be developed that deals with that.

But I think alternative dispute resolution, and I am hard-nosed about this, as a first encounter with applying a claim, and it is important for financial reasons, because if, in fact, 10 percent is a correct figure on defensive health care costs—I am inclined to think it is higher—but we are talking about not only the \$200 to \$250 billion worth of Federal medical expenditures, which probably are impacted by that 10 percent factor, but in what we are dealing with under the administration's proposal, a whole array of mandated benefits that some would argue is the equivalent of federalizing health care plus a greatly expanded new group of beneficiaries in the subsidized plans out there, you know, that then, perhaps, doubles the magnitude of what we are talking about. So it really has enormous consequences.

You know, we can argue at great length about what are defensive costs and what aren't, and I am sure that argument could go on and on and on. We have had ranges all the way from Surgeon General Koop, perhaps, putting it in the—associated with other things, in the 25 percent range. I believe the AMA did a study a few years ago on physician fees only that put it at 15 percent of physician's fees only, as I understand it.

But it isn't so much what physician's charge as what they order, and the number of situations of Medicare being billed \$900 for CAT scans because of a headache that you run into if you just walk out there are just enormous.

But there is something else that we are getting at here. I said in my opening statement, and I think, Dr. Clinton, you probably addressed the issue of clinical guidelines or practice guidelines. Somehow or another we have to include in this, in health care re-

form, a change of behavior so that the entire provider industry in this country becomes cost conscious. I think that probably medical liability gets used as a whipping boy for an unwillingness to really get on with the business of setting clinical guidelines and practicing good peer review in a provider setting.

Well, if we believe that managed health care, and probably most of us do in one form or another think it is a constructive move, we need to do those things that enable that to happen. And I think malpractice reform is essential, is an essential piece of that puzzle, and it isn't something that we should be equivocal about.

And I think there is a will to deal with that on the part of the public. I have kicked it around in my own constituency at great length and, on balance, the public is very much in favoring of not dealing with this.

No one wants to beat up on lawyers, but I do think the lawyers need to help us lead the way in finding the right kind of pattern of alternative dispute resolution.

Let me just—if I could just nail this one point down maybe, Dr. Clinton. Do you think that if 10 percent of health care costs are defensive that then 10 percent of Federal expenditures for health care find their way into defensive and unnecessary procedures, and therefore if we can get a handle on them could be reallocated for some other more constructive purpose?

Mr. CLINTON. I think you could lay out any number and we could find someone who would use that number. We have not undertaken that study.

Mr. MCMILLAN. Well, you leveraged the 10 percent. I would put 20 percent on it.

Mr. CLINTON. The 10 percent was that I think within any given clinical practice guideline, let's take the one on depression, let's take the one on urinary incontinence, if that were followed, it was our general sense that we could save money on the order of 10 percent. It was a professional judgment. It was not a calculation.

But take a clinical guideline like the one for depression. If you treat depression early with the right drugs you prevent recurrences and prevent the magnitude of the recurrences. So, even something like depression, which I thought the panel might say you are going to have to spend a lot more money at this, they indeed said if you do it right you are going to save money.

If you manage pain right in a hospital, you get patients out faster. If you get them out a half day faster that is a lot of money.

So, by doing things along the lines or parameters of clinical practice guidelines, I think there are opportunities to save money. Much of what was not done in the past, or what was done in the past was a combination of uncertainty and some concern that someone was going to second guess our judgment. So they are all interrelated.

And I would simply conclude saying you can't deal with one without the whole. We really need to fix the entire system, and I think medical liability is a part of it, clinical practice guidelines weaves into that. To think that we can do just one part and that will solve it, I think is blind to the fact that we have an interrelated system that doesn't work well. The intent here is to try to pull it together.

Mr. MCMILLAN. I think that is good advice.

Mrs. COLLINS. Well, we thank you for appearing before us this morning. We are now prepared for our second panel.

Mr. HASTERT. Madam Chairwoman, before this panel leaves could I just make this one comment, a very short comment?

Mrs. COLLINS. Sure.

Mr. HASTERT. You know, I think you hit a nail on the head. One of the things that I think in any health care plan that we want to do is to be able to give doctors the ability to do what they are trained to do, and that is to get them to expedite their own good judgment and not to be so sensitive that, you know, they have to give \$5,000 worth of tests out there just to protect themselves, because, you know, some day that patient is going to die or that patient is going to get more ill, and, you know, to link that with what a doctor is trained to do.

The best cost effective thing that we can do in our health care plan today is to allow doctors to do what they are trained to do and that is to take care of people in the best way they can, and not be ying-yanged around by the threat of a medical malpractice suit.

Mr. CLINTON. We use the phrase to improve decision-making, and I think we are saying the same thing.

Mrs. COLLINS. Again, thank you, gentlemen, for appearing before us. We very much appreciate your testimony this morning.

[The following letter was received for the record:]



U.S. Department of Justice

Office of the Associate Attorney General

The Associate Attorney General

Washington, D.C. 20530

January 10, 1994

The Honorable Alex McMillan
United States House of Representatives
Washington, D.C. 20515-3309

Dear Congressman McMillan:

Thank you for your letter of November 24, 1993. I am pleased to respond to your questions and to continue the important dialogue about medical malpractice reform proposals in the President's Health Security Act.

Your letter, which asks specifically about the absence of caps on non-economic damages in malpractice suits, states that "there is growing evidence that malpractice lawsuits, or the threat of those suits, are directly responsible for a large portion of the over-utilization of many diagnostic services that are not medically necessary but must be done to protect the provider and the hospital network from litigation."

The President shares your concern that medical malpractice reform is a critical part of health care reform. The President's plan provides serious malpractice reform. We are not persuaded that current experience or studies show that caps on economic damages will eliminate the practice of defensive medicine.

A recent paper by the Office of Technology Assessment (September, 1993) entitled "Impact of Legal Reforms on Medical Malpractice Costs" states:

"The impact of changes in malpractice cost indicators on physician behavior is not known. Although reducing malpractice cost indicators through medical malpractice reform might encourage physicians to limit defensive ordering of tests and procedures, it may also dampen whatever beneficial effects the medical malpractice system has in deterring negligent medical practice. The advisability of such changes under a new health care payment regime--particularly one with greater incentives to reduce costs--is a policy issue that deserves careful consideration." Id. at 3.

At the hearing on November 10, 1993, Chairman Waxman noted that in his state of California, which has enacted comprehensive medical malpractice litigation reform including caps on non-economic damages, "we really know of no evidence or very little evidence of defensive medicine . . . having decreased as a result of those tight tort laws."

Similarly, Congressman Cooper stated that a number of medical societies had admitted to him privately that

"if we could pass the statute of their dreams . . . it would reduce unnecessary testing by less than one percent. . . . In fact, one of the more honest spokespersons told me that it would take a generation of doctors to die off before they would really change practice behavior, because once you learn something and learn it well, and you have been taught to disregard cost, and you have been taught on a fee-for-service basis in which volume is rewarded, it is awfully hard to teach an old dog new tricks."

If your staff could provide mine with further information on the growing evidence to which you refer, we will of course be eager to include it in our analysis.

As I testified at the hearing, the President's approach to medical malpractice reform tries to balance the competing considerations involved through a coordinated package of proposals that will reduce the pursuit of non-meritorious litigation and provide greater flexibility in the payment of awards, without imposing arbitrary limits on some aspects of damage recoveries. It was in that context that I testified that the question of caps on non-economic damages was properly left to the individual states.

Let me briefly review the set of proposals included in the President's plan, and how they work together to improve the system and address the legitimate concerns of both health providers and patients:

- First, the President's plan encourages consumers and providers to try to resolve controversies through more informal and less costly mechanisms before resorting to litigation. Every health plan will be required to develop at least one alternative dispute resolution ("ADR") mechanism such as mediation or arbitration, and every claim of medical malpractice must go through that ADR process before a suit can be filed. The thinking behind this proposal is that ADR can be used to successfully resolve many kinds of

cases, including those in which liability is clear but in which the damages are relatively small. These are precisely the kinds of cases for which poor and middle class patients have been denied representation in the past because contingent fees cannot adequately compensate attorneys for the work required to take them to trial. We also believe that the ADR requirement will reduce the volume of malpractice litigation and provide a forum that will be less stressful and alienating for doctors. Consumers are still ultimately entitled to their day in court, but this structure for settling malpractice claims before they get to court has real rewards for both patients and providers.

- Second, the proposed Act limits the amount of a lawyer's contingency fee to no more than one-third of the amount recovered in a malpractice case. States, however, may impose lower limits.

- Third, before a lawyer can file a medical malpractice suit, he or she must first submit an affidavit by a qualified medical specialist supporting the alleged negligence.

- Fourth, either party may request that an award be paid periodically rather than in a lump sum. The judge has discretion to determine the schedule based on the needs of the injured party.

- Fifth, the collateral source rule is abolished, preventing plaintiffs from getting a double or "windfall" recovery in situations in which the injured party is entitled to insurance or other compensation for the same injuries at issue in the malpractice suit, including health care costs and the value of lost wages. As I explained in my testimony, elimination of the collateral source rule will, in many cases, significantly reduce both a plaintiff's recovery and the related attorney's fees.

- Sixth, the proposed legislation provides that the National Practitioner Data Bank will make available to the public the names of practitioners who have a pattern of malpractice payouts or licensing sanctions.

- Seventh, the President's plan provides funds for two important demonstration projects -- one to develop practice guidelines and the other to demonstrate whether substituting liability by the health plan for liability by individual providers will lead to improvements in quality, reductions in defensive medicine and better risk management.

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Taking all of the above proposals into account, my testimony was that "if we address the problems of frivolous lawsuits and the lack of effective quality measures, and if we place limits on double recoveries, there is no reason to place arbitrary limits on damages." I explained further that the problem with caps is that while the impact they have on health care costs generally appears small, caps can work great injustice in medical malpractice cases in which the injuries are most severe and compensation above an arbitrary limit is most justified.

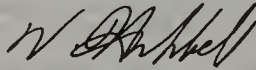
It was at this point that I went on to say that, in deference to the fact that medical malpractice law is traditionally a state function, the President's proposal allows individual states to set caps on recovery of non-economic damages if they wish.

We believe that in this area the best course is to allow the states to address the issue of caps on damages as they see fit. Many states have caps on non-economic or other damages in medical malpractice suits, and that is a decision best left to the states. States may balance the effect of caps on defensive medicine versus hardship on those who are seriously injured as a result of negligence.

That malpractice suits may begin to "drift" to those few states prohibiting caps seems unlikely to me because medical malpractice cases can only be brought where the alleged negligent acts or omissions occurred or where a party resides.

I hope I have responded to your concerns. I know very well that we are discussing complex issues about which reasonable persons can differ, and where there is no uniquely correct answer. I look forward to continuing a dialogue with you as the medical malpractice provisions of the Health Security Act receive ongoing scrutiny in Congress.

Sincerely,



Webster L. Hubbell
Associate Attorney General

cc: The Honorable Henry Waxman
Chairman, Subcommittee on Health and the Environment

The Honorable Cardiss Collins
Chairwoman, Subcommittee on Commerce, Consumer
Protection, and Competitiveness

Mrs. COLLINS. Our next panel will be Mr. Frank Cornelius, Troyen A. Brennan, who is a Professor of Law and Public Health at the Department of Health Policy and Management at the Harvard School of Public Health; Ms. Pamela Gilbert, who is the Director of Congress Watch, Public Citizen; Dr. Richard Green, from the American College of Obstetricians and Gynecologists; Ms. Laura Wittkin, Executive Director of the National Center for Patients Rights; and Dr. Joseph T. Painter, who is a member of the Board of Trustees of the American Medical Association.

Won't you come forward, please?

STATEMENTS OF RICHARD P. GREEN, ON BEHALF OF AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS; JOSEPH T. PAINTER, PRESIDENT, AMERICAN MEDICAL ASSOCIATION; FRANK CORNELIUS, CARMEL, INDIANA; PAMELA GILBERT, DIRECTOR, PUBLIC CITIZEN'S CONGRESS WATCH; LAURA WITTKIN, EXECUTIVE DIRECTOR, NATIONAL CENTER FOR PATIENT'S RIGHTS; AND TROYEN A. BRENNAN, PROFESSOR OF LAW AND PUBLIC HEALTH, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, HARVARD SCHOOL OF PUBLIC HEALTH

Mr. GREEN. Chairwoman Collins, Chairman Waxman, and members of the subcommittees, I am Richard P. Green, a practicing OB-GYN here in the District of Columbia. I am testifying on behalf of the American College of Obstetricians and Gynecologists, an organization representing more than 3,000 physicians providing women's health care. I wish to thank the Chairs and the members of these two subcommittees for your interest and giving me the opportunity to testify about a problem that begs to be rectified: the adverse effects of the liability crisis on obstetric care.

I think the best way to demonstrate the problem associated with the liability system is through my personal story. I was born and educated in the District of Columbia. I am a Howard Medical School graduate and have practiced here since 1973. I treat Medicaid and other indigent patients in my practice as well as private-pay and third-party insured patients.

I still practice obstetrics, even though I will pay more than \$60,000 this year for my malpractice insurance premium. Comparatively speaking, my malpractice premium pales in comparison to colleagues of mine who practice in Florida. Their yearly premiums can be as high as \$137,000.

I am here today because I am concerned about my ability to continue to serve my obstetric patients. Some of my colleagues have given up the practice of obstetrics. Others have given up the practice of medicine altogether. A close personal friend of mine stopped practice completely and went to work for the Food and Drug Administration.

Unless the Federal Government begins to address the problems related to malpractice, I am afraid that many other colleagues and I will be forced to make similar choices. Let me briefly describe the problems and suggest what can be done to address effectively the current medical liability situation.

According to a 1992 survey of the ACOG's membership, 12.3 percent after OB-GYN's nationally have quit obstetrics and almost 25

percent had to decrease the amount of high-risk obstetric care they provide. Almost 80 percent of my Board certified colleagues had at least one claim filed against them.

In the State of New York, nearly 90 percent of the OB-GYN's have been sued, with the average number of suits filed against these New York doctors being four. Clearly the liability crisis is not primarily due to the bad doctor. The major problem is neither mine nor even that of the OB-GYN's who have quit obstetrics because of malpractice. The problem is for our patients who ultimately suffer from the liability situation, those who have difficulty finding an OB-GYN to treat their high-risk pregnancies and those for whom obstetric care is unaffordable because of the liability premiums their OB-GYN's have to pay.

The bottom line is that pregnant women in many areas of the country are having difficulty obtaining prenatal care. This is certainly true here in the District of Columbia. While it has never been safer for a woman to have a baby, it has never been riskier for a doctor to deliver one.

I decided to become an OB-GYN because of the thrill of my first delivery during medical school. It was the first time anyone had ever called me Dr. Green. My instructor held my hands in his and helped me guide a new little boy from his mother's birth canal into the world. There are few experiences in life which can match the satisfaction and joy of this.

But lately, this joy has been diminished. The delivery suite has become a battleground with patients and physicians pulled apart by an adversarial tort system which is out of control. Obstetrics care will become unaffordable and unavailable if we allow liability risks and insurance premiums to continue to drive out dedicated professionals. We cannot allow the situation to deteriorate further and jeopardize the health of women and their infants in this country.

To avoid this, uniform Federal minimal standards for tort awards need to be enacted, as detailed in our written statement. While few States have adequate tort reforms, the District of Columbia, our Nation's capital, is the only jurisdiction with none.

We at ACOG are pleased that President Clinton's proposal, the Health Security Act, includes substantive tort reforms. Many of the reforms in the President's plan have been shown to be effective and are supported by the College.

Advocating for Federal tort reform for all medical malpractice cases is a major step forward. However, we promote strengthening some of the included reforms and adding other reforms such as a ceiling on noneconomic damages and a reasonable statute of limitations for adults and minors.

In closing, I urge Congress to seize the opportunity and pass meaningful tort reform. Today's deplorable liability situation can no longer wait. It would be a disservice to those seeking health care if we enact health care reform without addressing this critical problem.

On behalf of the women seeking obstetric and gynecological care in this country, I beg you to pass legislation that will allow them access to the care that they want and so rightfully deserve.

Madam Chairwoman, I thank you.

[The prepared statement of Dr. Green follows:]

STATEMENT

of the

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Richard P. Green, MD, FACOG

Chairman Waxman, Chairwoman Collins and Members of the Subcommittees, I am Richard P. Green, MD, a practicing obstetrician-gynecologist here in the District of Columbia. I am testifying on behalf of the American College of Obstetricians and Gynecologists (ACOG), an organization representing more than 33,000 physicians providing women's health care. I wish to thank the Chairs of these two Subcommittees and the Members for your interest in this serious issue and giving me the opportunity today to testify about a problem that begs to be rectified -- the adverse effects of the liability crisis on obstetric care.

I think the best way to demonstrate the problems associated with the liability system is through my personal story. I was born in the District, educated here, graduated from Howard Medical School, and have been in private practice here since 1973. I treat Medicaid and other indigent patients in my practice, as well as private pay and third party insured patients. I still practice obstetrics, even though I will pay more than \$60,000 this year for my malpractice insurance premium. Comparatively speaking, my malpractice premium pales in comparison to colleagues of mine who practice in Florida -- their yearly premiums can be as high as \$137,000.

I am here today because I am concerned about my ability to continue to serve my obstetric patients. Some of my colleagues have given up the practice of obstetrics; others, the practice of medicine. A close personal friend stopped practice completely and went to work for the FDA. Unless the federal government begins to address the problems related to malpractice, I am afraid that many other colleagues and I will be forced to make similar choices. Let me briefly describe the problem and suggest what can be done to address effectively the current medical liability situation.

According to a 1992 survey of ACOG's membership, 12.3% of obstetrician-gynecologists nationally had quit obstetrics and almost one-quarter had decreased the amount of high-risk obstetric care they provide because of the risk of malpractice. The same survey showed that almost 80% of my board-certified colleagues -- physicians with demonstrated knowledge in women's health and who have gone through a rigorous certification process -- had at least one claim filed against them. In the state of New York, nearly 90% of obstetrician-gynecologists have been sued, with the average number of suits filed against these New York doctors being four. Clearly, the liability crisis is not primarily due to the "bad doctor."

The major problem is neither mine nor even that of the obstetrician-gynecologists who have quit obstetrics because of malpractice concerns. The problem is for our patients who ultimately suffer from the liability situation -- those who have difficulty finding an obstetrician-gynecologist to treat their high-risk pregnancies, and those for whom obstetric care is unaffordable because of the liability premiums their obstetrician-gynecologists have to pay. The bottom line is that pregnant women in many areas of the country are having difficulty obtaining prenatal care. This is certainly true in the District. While it has never been safer for a woman to have a baby, it has never been riskier for a doctor to deliver one.

I decided to become an obstetrician-gynecologist because of the thrill of my first delivery during medical school. It was the first time anyone had ever called me "Dr. Green." My instructor held my hands in his and helped me guide a new little boy from his mother's birth canal into the world. There are few experiences in life that can match the satisfaction and joy of this.

But lately this joy has been diminished. The delivery suite has become a battleground, with patients and physicians pulled apart by an adversarial tort system which is out of control. Obstetric care will become unaffordable and unavailable if we allow liability risks and insurance premiums to continue to drive out dedicated professionals. We cannot allow the situation to deteriorate further and jeopardize the health of women and their infants in this country.

I would now like to take the opportunity to share with you a story about one of my colleagues who practices in West Virginia. She has testified twice before the U.S. Senate -- once in 1986 and, most recently, in 1991. The first time she testified, her liability premium had just increased to \$13,241 which, at that time, was a 400% increase. She begged the Senate to take action before physicians like her were forced out of practice.

When she returned to testify in 1991, she had already given up the practice of obstetrics at age 35 because her malpractice insurance premium had risen to \$40,000 in 1990. Because of the economic situation in West Virginia, she couldn't pass along her increased costs to her patients, so she had no other choice than to drop her obstetric practice. She said before the Senate she "could not have believed in 1986 that she would be back testifying without the passage of a single piece of federal legislation to address the problem" of the liability crisis. I certainly hope I don't have to follow in her footsteps.

For these reasons, the President and Mrs. Clinton recognized that malpractice reform was an essential part of health care reform. We were pleased to see some steps toward achieving true malpractice reform in the President's package. The current system for

compensating injured parties is time-consuming, with average delays of almost five years in ob/gyn cases before payment is made. It is also inefficient, with as little as 28% of the malpractice premium dollar going directly to the injured parties.

The Administration has recognized that the federal government needs to take the lead on malpractice reform. The federal government, as the single largest purchaser of health care services, has a strong interest in insuring the availability of quality medical care and managing its cost. As part of that concern, the President has recognized that the federal government must take the lead in effectively addressing medical liability concerns.

Mandatory Collateral Source Offset

We were pleased to see that the Clinton plan allows for elimination of the collateral source rule and provides for a mandatory offset against awards for compensation received from other sources. The collateral source rule allows plaintiffs double recoveries since they can recover from government or private insurance companies and also in tort. To the extent that injuries are compensated more than once, insurance costs for all are increased.

Mandatory, Non-Binding Alternative Dispute Resolution (ADR) System

The creation of a mandatory ADR mechanism in the Administration's proposal is encouraging and could well be beneficial. Our current medical malpractice system needs innovative mechanisms for determining whether individuals are negligently injured in the course of receiving health care services, and compensating those who are determined to have been negligently injured. However, we are concerned that by not making ADR

decisions binding, costs will be increased as there is nothing to stop a plaintiff or defendant who loses at the ADR level from proceeding with a court case. As a result, cases may, in effect, be tried twice. While ACOG strongly supports alternatives to the tort system, we are concerned this provision is inadequate.

Limits on Attorney's Contingency Fees

The proposed limit on attorney fees of 33 1/3% is a start, but hardly adequate. A sliding scale contingency fee schedule would be more appropriate because that would ensure that patients, not lawyers, receive the bulk of awards.

Periodic Payment of Awards

It was heartening to see the provision for periodic payments of awards in the Administration's proposal. Periodic payments provide another way to reduce the costs of liability actions while assuring that the plaintiff receives a fair recovery. In addition, if the tort award for future damages is paid out over time rather than all at once, both the plaintiff and defendant benefit. The plaintiff is assured that money will be there when it is needed and the defendant's payout is made more predictable.

Certificate of Merit

Furthermore, the presence of a certificate of merit in the Clinton plan is encouraging. A certificate of merit is one of the essential elements of the National Medical Liability Reform Coalition (NMLRC), of which ACOG is a prominent member. (The NMLRC is a broad-based group which believes that the cost containment, quality and access objectives of any

comprehensive health care reform proposal cannot be achieved without effective medical liability reform.) According to ACOG's latest survey, almost 50% of all claims are dropped or settled without payment, so a procedure which could provide for more thorough medical screening of claims could be helpful.

Demonstration Projects

The Clinton plan provides for demonstration projects on enterprise liability, which substitutes individual physician liability with liability on the part of the health plan, and the use of practice guidelines as an affirmative defense. These could provide useful information on how to improve our system of determining whether a patient was injured in the course of treatment and compensating those who are.

While the President's plan is a good start, the provisions in the plan fall short of what ACOG believes are necessary if we are to achieve progress in addressing this critical problem. We are not alone in this criticism; in fact, former Surgeon General C. Everett Koop recently said that one of the plan's shortcomings was "its failure to address the skyrocketing costs of malpractice." Therefore, I have a few suggestions that ACOG believes can help remedy our ailing tort system.

A limit on noneconomic damages is an essential element of meaningful tort reform. Such caps have been an element in effective tort reform at the state level. Congress' own Office of Technology Assessment (OTA) reported in a September 1993 background paper that caps on damage awards were the only type of state tort reform that consistently showed

significant results in reducing the malpractice cost indicators. The OTA found that a cap on noneconomic damages was effective in lowering payment per paid claim -- thus reducing malpractice insurance premiums. A cap on noneconomic damages does not limit in any way recovery for economic losses, such as medical care expenses, rehabilitation, or lost income. It is a reasonable approach since the plaintiff still receives full compensation for economic damages. ACOG believes \$250,000 is a reasonable cap on noneconomic damages.

Another element missing from the Clinton plan is reform of the statute of limitations for malpractice claims to be brought to court. This is important to obstetrician-gynecologists, both for cases involving adults and minors. Specifically, ACOG advocates that a claim must be filed within two years of the date by which an alleged injury should have reasonably been discovered, but in no event more than four years from the time of the alleged injury. In the case of alleged injury to children under four years of age, a claim could be brought until the child's eighth birthday.

Some states' statutes of limitation for medical liability claims permit plaintiffs an extraordinary amount of time within which to bring suit, particularly in the case of minors where some jurisdictions allow a suit to be brought beyond the age of maturity. For an alleged injury at birth, actions can be brought in some jurisdictions, including the District of Columbia, after more than twenty years. Such cases are obviously difficult to defend. Even good memories fade after twenty years, the whereabouts of all relevant parties may not be known, and medical practices may have changed dramatically. This "long tail" phenomenon presents major problems for insurers in establishing rates and reserves and for

defendants in producing evidence and witnesses.

There are also similar problems with a liberal "discovery rule," which may toll the statute until an injury is discovered or reasonably should have been discovered. Our limits would allow a reasonable time for actions to be brought, while providing a point beyond which a suit cannot be brought. This is, in our view, fair to all parties.

ACOG also supports a change in burden-of-proof law to allow use of "clear and convincing evidence" in a case where a health care professional who provided delivery services but not prenatal care is sued, rather than the current requirement of "preponderance of evidence." Unfortunately, the Clinton proposal does not propose a change in the burden-of-proof law. There is an increased risk of an adverse outcome when a woman has not received prenatal care. Adjusting the burden of proof recognizes the increased difficulties the health care professional faces in these circumstances, while still allowing the patient who thinks she was treated negligently recourse.

Our ideas for tort reform are not radical -- in fact, many of them are present in most of the health care reform bills under consideration in the U.S. Congress. In closing, I urge Congress to seize opportunity and pass truly meaningful tort reform that goes beyond what President Clinton has proposed -- today's deplorable liability situation can no longer wait. It would be a disservice to those seeking health care if we enact health care reform without addressing this critical problem. On behalf of the women seeking obstetric and gynecologic care in this country, I beg you to pass legislation that will allow them access to the care they want and deserve.

Mrs. COLLINS. Dr. Painter?

STATEMENT OF JOSEPH T. PAINTER

Mr. PAINTER. Thank you, Madam Chairwoman, members of the subcommittee. My name is Joseph Painter and I am Vice President for Health Policies at the M.D. Anderson Cancer Center in Houston, Tex. I am also President of the American Medical Association.

In the nineties, we are beyond the point of asking whether there is a crisis in the current tort system. We have reached a point where definitive action is needed.

Many reliable studies have affirmed that without substantial reform the current liability system is unable to resolve medical claims effectively and efficiently. For those patients who have been harmed by malpractice, the current system frequently is unresponsive or inadequate. AMA believes that patients who have been injured due to negligence should be fairly compensated.

Unfortunately, the current system has failed to provide fair or even any compensation to many meritorious situations, and legal and administrative costs unduly diminish legitimate awards. The system also fails in weeding out poor practitioners and far too many doctors are sued.

Society as a whole also is harmed by the present system. Spiraling costs generated by our Nation's liability system are borne by everyone. We cannot long sustain the six figure liability premium or the cost of defensive medicine. We cannot afford to not take action, as nationwide liability reform could save \$35.8 billion over the next 5 years by decreasing the cost of premiums and the practice of defensive medicine.

Looking beyond this economic concern, serious societal harm caused by the liability is reduced access to health care. Increasing premiums and the threat of liability have caused physicians to abandon practices, as you just heard, and certain services decreased in all areas of the country.

Also, the threat of liability severely inhibits medical innovation and deprives health care professionals of certain pharmaceutical and medical devices that are needed to optimally treat patients.

These are real problems, and unless the current liability system is fundamentally changed, effective health system reform will never be achieved. Reforms that work, such as those adopted in California tell us that reform can produce dramatic effects by promoting settlement of valid claims, discouraging frivolous litigation, and reducing the time required for claims resolution.

The four key revisions that have proven effective in California are the \$250,000 ceiling on noneconomic damages, mandatory periodic payment of future damages, mandatory collateral source award offsets, and a sliding scale regulation of attorney contingency fees.

Patient safety must also be a part of the package, including strengthening of State licensing and disciplinary boards, and establishing appropriate injury prevention programs in every medical care setting.

We are here today to tell you that 20 years of limited State attempts at reform have proven to be inadequate and a nationwide solution must be enacted. We are pleased that the administration's

proposal does address this matter. However, we believe that this proposal fails to achieve the needed result by its failure to impose monetary limits on awards for pain and suffering, the most single important factor in containing health care liability costs.

It also fails in its restriction of attorney contingency fees to 33½ percent of the award, the share of the awards now taken in most of these cases. This is virtually no limit at all.

In conclusion, we are encouraged by a bill such as H.R. 1625, sponsored by Representative Nancy Johnson and H.R. 1989, sponsored by J. Alexander McMillan, that emphasize alternative dispute resolution and strong traditional tort reform.

Madam Chairwoman, the problems associated with excessive litigation are not new. The system is broken. It needs to be fixed. Steps can be taken to better meet the needs of injured patients who deserve to be fairly compensated to reduce the frictional cost of the process and to assure that physicians can still offer medically necessary services to all patients.

We now appeal to Congress to provide us a rational and equitable means of resolving this crisis.

Thank you.

Mrs. COLLINS. Thank you.

[Testimony resumes on p. 350.]

[The prepared statement of Dr. Painter follows. Attachments thereto are retained in subcommittee files.]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

**Subcommittee on Health and the Environment
Subcommittee on Commerce, Consumer Protection, and Competitiveness
Energy and Commerce Committee
United States House of Representatives**

Presented by
Joseph T. Painter, MD

**RE: Health System Reform:
Issues Relating to Medical Malpractice**

November 10, 1993

Mr. Chairman, Madam Chair, and Members of the Subcommittees:

My name is Joseph T. Painter, MD. I am a physician with a specialty in the field of cardiovascular disease and am Vice President for Physician Referral, Development and Extramural programs at the M.D. Anderson Hospital in Houston, Texas. I am also President of the American Medical Association (AMA). Accompanying me are Hilary E. Lewis, JD, of the AMA's Division of Federal Legislation and Martin J. Hatlie, JD, of the AMA's Department of Professional Liability. On behalf of the AMA, I am pleased to have this opportunity to testify regarding the very serious problems that stem from our litigious society and our current system of resolving medical liability claims.

As the nation awaits the sweeping changes to be effected through reform of the entire health care delivery system, an important challenge confronting you as the architects of reform is overhaul of the medical liability litigation system. By accepting this challenge and

enacting meaningful medical liability reform, you have the opportunity to increase access to medical services, eliminate much of the need for medically unnecessary treatment, improve the doctor/patient relationship, help prevent avoidable patient injury, and curb the single most wasteful use of precious health care dollars -- the financing of medical liability litigation. The sad truth is that our nation's medical liability system has the highest administrative costs of any injury reimbursement mechanism in the world, spending almost sixty cents of every premium dollar on attorney fees, expert witnesses, and insurance company overhead. What is even worse, the current civil justice system as it exists in most jurisdictions, fails to accomplish many of the critical goals of effective dispute resolution -- access to legal process, appropriate compensation for those injured due to negligence or the use of a medical product, deterrence of negligence, or the effective identification of incompetent health care providers. The system is fraught with inequities, compensating a few with lottery-like awards, yet denying legal redress to most legitimate claimants. In fact, medical liability litigation, accurately dubbed "high stakes" litigation by the RAND Corporation, has created numerous problems for this country's health care system -- all to the detriment of patients, physicians, health care providers, society and the federal government (as the largest single payer for health care in this country).

Defining the Problem

For many years, this country has grappled with the growing inability of the tort system to resolve medical liability claims in a fair, timely and effective manner. The debate has

intensified during the past two decades as medical liability problems have reached crisis levels in many states, and as society has shouldered the "side effects" of the crisis.

The issue of medical liability continues to be heated despite 20 years of reform efforts in the states. Clearly, much remains to be done at the federal level. Every recent poll has demonstrated that the American public strongly supports effective medical liability reform as a component of health system reform. According to a 1991 Gallup Poll, 77 percent of Americans think malpractice lawsuits and awards are an important reason for the rising costs in health care. The Los Angeles Times found that given seven possible reasons for expensive health care in this country, people are most likely to name malpractice suits. Studies conducted by the Harvard School of Public Health, the General Accounting Office (GAO), and the Department of Health and Human Services Task Force on Medical Malpractice and Insurance, just to name a few, concur with the following consensus: The current tort system, without substantial modification or reform, is unable to resolve medical liability claims effectively and efficiently.¹

It also is important to note what the problem is not -- medical negligence is not solely the fault of "bad" or "incompetent" doctors. Rather, studies have shown that all doctors, even the best doctors, can and do make mistakes. We submit that avoidable mistakes are never

¹ These studies also reached agreement that the reform model adopted in California most effectively discourages frivolous claims, promotes settlement of valid claims and expedites claims resolution. These reforms include:

- 1) limitations of \$250,000 on recovery on noneconomic damages;
- 2) mandatory offset of collateral sources of plaintiff compensation;
- 3) decreasing sliding scale regulation of attorney contingency fees; and
- 4) periodic payment for future award of damages.

acceptable. The medical community -- and the medical liability insurance community -- is committed to continuing efforts to reduce the incidence of injury even further and strongly supports reform efforts to promote patient safety and identify incompetent or unethical physicians. Our efforts alone, however, are not enough to remedy the many harms that the current tort system perpetuates.

Patients Are Harmed

The AMA strongly believes that patients who have been injured due to negligence should be fairly compensated, and that our dispute resolution mechanisms should promote this goal. Unfortunately, the current tort system has failed the patient population.

A February 1990 study by the Harvard School of Public Health of hospital admissions in 1984 shows that of the 1% of patients whose medical records indicated some negligent treatment, only 12.5% filed liability claims. Significantly, only half of those patients -- 6.25% -- received compensation from the tort liability system.

Other data show that even when patients pursue compensation, other parties to the system reap disproportionate benefits. Attorneys' fees and expenses (both plaintiff and defendant) account for 38% of total monies spent on resolving medical liability claims. (See Appendix A.)

Ironically, while our system ostensibly is designed to compensate the injured, the RAND Corporation estimates that only 43 cents of every dollar spent in medical liability litigation reaches injured patients.

In addition, patients typically wait much too long for resolution of their claims -- six to ten years in most urban areas. The time and cost commitment involved in pursuing litigation impedes redress of injury and denies injured patients meaningful access to the legal system by discouraging attorneys from accepting cases where damages are not expected to be very high.

Physicians Are Harmed

Medical liability awards soared by more than 1000% from 1960 to 1984. A study reported in 1988 showed that the average doctor has a 37% chance of being sued for professional liability in his or her lifetime. This increases to 52% for a surgeon and 78% for an obstetrician. Perhaps the most compelling evidence of the current system's failure is the fact that a physician's chance of being sued for medical liability bears little relation to whether he or she has been negligent. The Harvard data show that 80% of the claims for medical negligence filed in New York did not correspond with a negligent adverse event. Stated differently, of those plaintiffs who sued their doctors, only 20% had cases based on evidence of a negligent adverse event. These findings reinforce the GAO's estimate that nearly 60% of all claims filed against physicians are dismissed without a verdict, settlement, or any payment of compensation in the plaintiff's favor (1987 GAO Report, "Medical Malpractice, Characteristics of Claims Closed in 1984"). These facts are further reinforced by an AMA poll conducted in 1992 revealing that 63% of the population believes that the number of malpractice suits against doctors is higher than justified. The message implicit in these numbers is that the current tort system as it functions in most states is not effectively resolving medical liability claims or deterring medical negligence.

Society Is Harmed

Costs - Although patients, physicians, and health care providers are most directly harmed by the present liability system, society as a whole also is harmed. The spiraling costs generated by our nation's dysfunctional liability system are borne by everyone. One

component of the cost issue is the exorbitant amount attributable to physicians' (and other providers') professional liability premiums, which have been a significant factor contributing to the growth in patients' medical and health care bills. In the 1980s, professional liability premiums were by far the fastest growing component of physicians' practice costs, increasing at an annual average rate of 15.1% between 1982 and 1989. (See Appendix B.) Estimates show that for each baby delivered in Florida, \$1,119 goes toward payment of liability insurance, and average premiums paid by self-employed physicians tripled in the 1980s. The cost is especially heavy for some high-risk specialists in certain states whose premiums have exceeded \$100,000 and approach as much as \$200,000 annually. All of us as patients ultimately bear the burden of the high premiums paid by physicians, hospitals, and medical product producers when their costs are passed on in the form of more expensive health care services. The estimated annual cost of liability insurance for physicians and health care facilities has been placed at more than \$9 billion in 1991 and continues to grow.

Yet another liability expense factor is the cost attributable to "defensive medicine." Aptly named, defensive medicine is a phenomenon whereby physicians, faced with a 38% chance of being sued regardless of the quality of care they provide, defend against future liability claims by providing services in cases where that care might not have been provided absent the fear of litigation. A study published in Medical Economics found that, as a result of this practice, 70% of physicians order more consultations, 66% order more diagnostic tests, 54% order more follow-up visits, and 28% perform procedures they ordinarily would have delegated to other medical personnel. The AMA estimates that this practice added an

additional \$15.1 billion to the cost of health care in 1989.² In 1991, the cost of defensive medicine was estimated to be as high as \$25 billion. These costs have adversely affected the ability of some health insurers to continue to provide full benefits.

According to a report prepared by Lewin-VHI released in February 1993, comprehensive medical liability reform as a component of health care delivery system reform could save an estimated \$35.8 billion over the next five years by curbing premium cost and many defensive medical practices. Once achieved, the Lewin study predicts that tort reform savings will accrue at an accelerated rate as practice patterns begin to change.

Medical Innovation - Another societal harm that results from the present system is that the threat of liability acts to inhibit medical innovation and deprives health care professionals of certain medicines and medical devices needed for optimal patient treatment. For example, the threat of litigation prompted seven of eight pertussis vaccine manufacturers to withdraw from the market between 1960 and 1985, even though no sound scientific study has even confirmed a cause and effect relationship between the vaccine and any adverse neurological reaction. To prevent a dangerous shortage of the vaccine, the federal government established a compensation fund financed by an increase in the cost of the vaccine. Similarly, excessive litigation costs have been cited as the primary reason for the manufacturer of the morning sickness drug Bendectin to withdraw its product from the market, even though there is no credible scientific evidence to this day linking it to birth defects. Patients suffer needlessly

² Like other defensive measures, all defensive medicine cannot be characterized necessarily as overuse, but can reflect necessary improvements and added value in the provision of patient care.

because no substitute therapy for morning sickness has been developed -- the product liability litigation risk is just too high. According to most recent data, \$10.8 billion was paid to claimants in all medical product liability cases in the U.S. in 1990 -- exclusive of associated administrative and legal defense costs. Unfortunately, this climate has caused many companies to refrain from pursuing some research projects that could lead to medical/patient care breakthroughs. An April 1992 report in Science magazine indicated that several companies have abandoned research projects or postponed clinical trials of promising vaccines to fight AIDS due to liability concerns.

Access to Health Care - Perhaps the most serious societal harm caused by the liability system is reduced access to health care. Increasing premiums and the threat of liability have caused physicians to abandon practices and to cease provision of certain services in various areas of the country. Access to health care includes: (1) the availability of a physician or other health care professional to treat a patient; (2) the willingness of the physician or other professional to treat a patient; and (3) the affordability of the medical services.

Physicians and health care institutions have limited their medical practices in response to the liability climate. These restrictions on access to health care services have been seriously felt by obstetric patients, indigent patients, and those living in rural areas. Almost one out of eight obstetrician/gynecologists (12%) has dropped obstetrical practice as a result of liability risks.³ More than a half million residents of rural counties are without any

³ Professional Liability and its Effects: Report of a 1990 Survey of ACOG's Membership, American College of Obstetricians and Gynecologists.

physicians who provide obstetric services.⁴ Nor is this phenomenon limited to rural areas. An example of this problem was presented by Senator Riegle (MI) while chairing a 1991 hearing on health system reform, when he indicated that his family was unable to remain with its obstetrician of choice because that physician gave up obstetric practice. This did not happen to a citizen in a rural community. It happened to a U.S. Senator in the District of Columbia.

The AMA urges these Subcommittees to recognize that the present medical liability system significantly and directly impairs both access to health care and access to a workable compensation system for victims of malpractice. Until the negative aspects of the liability environment are alleviated, these access issues never will be fully resolved.

The Federal Response

Every shareholder in the medical liability system has the opportunity and the responsibility to make the system work better. The medical community is actively carrying out its responsibility to identify high-risk of injury situations and address through a variety of patient safety and loss prevention programs in virtually every medical setting. Unfortunately, we can do little to remedy the waste in our dysfunctional tort system. We hope that other participants in the system will heed the call to participate in this effort. As the federal government fashions a nationwide overhaul of the health care delivery system, it should act to realize a viable and consistent solution to the panoply of issues raised by medical liability.

⁴ Health Care in Rural America, Office of Technology Assessment, September 1990.

The litany of problems with the current tort system does not necessarily mean that the system must be abandoned. The AMA believes that a fault-based system that lowers the barriers to legitimate claims and reduces transaction costs can meet the needs of society. Reforms such as those adopted in the states of California and Indiana tell us that the current system is a good candidate for reform, and that reform can produce dramatic effects by promoting settlement of valid claims, discouraging frivolous litigation, and reducing the time required for claims resolution.

Federal Preemptive Tort Reform - The AMA supports federal legislative initiatives that create uniform standards of medical liability and preempt state law, except where corresponding provisions in state law are more effective. These uniform standards were incorporated in the 1975 California Medical Injury Compensation Reform Act (MICRA), a proven experiment in demonstrating what can be accomplished. The California reforms include: (1) limitations of \$250,000 on recovery of noneconomic damage awards; (2) mandatory offset of collateral sources of plaintiff compensation; (3) a decreasing sliding scale regulation of attorney contingency fees; and (4) periodic payment for future award of damages. We believe that these standards should apply to any claim arising from health care services offered by health care professionals or institutional providers in any state or territory.

Federal preemptive tort reform represents a bold approach, but the only one which bears the potential for truly advancing a nationwide solution to this complex problem. As the following comparisons demonstrate, the California model ensures full and adequate compensation for all actual losses, yet limits costs through various controls exerted on the

"lottery" aspects of the medical liability system, primarily through the central element of this law, the cap on noneconomic damages.

- Juries award more in medical malpractice cases than for the same injuries sustained in other contexts. Nationwide, there are more million-dollar-plus medical malpractice verdicts than any other type of personal injury claim. (Figure 1) In California, MICRA has decreased the number of million-dollar-plus verdicts per 1000 physicians to about half of the national average. (Figure 2)
- Nationwide, medical liability premiums constituted the fastest growing component of physicians' practice expenses in the 1980s. In California, however, MICRA reform succeeded in stabilizing and actually lowering (in real dollars) these insurance costs. (Figure 3) When MICRA was enacted in 1975, the medical liability premium costs in California were the highest in the nation. Today, they are one-third to one-half the costs of premiums paid in states without a MICRA-like cap on noneconomic damages. This illustrates the substantial value of this vital reform element. (Figure 4)
- Evidence suggests that California's MICRA reform has helped control the state's health care costs. From 1984 to 1986 -- the worst years of the last liability insurance crisis -- physician fees nationwide increased 13.1%, but only 9.2 % in California. (Figure 5) In 1991, the California medical care services index was lower than the national average, although other state consumer costs were climbing at a higher rate than the national average. (Figure 6)
- In 1975, Ohio also enacted tort reforms similar to those in MICRA. At that time, medical liability awards in that state accounted for 3.7% of the nation's total. By 1982, that percentage dropped to 2.9%. While constitutional challenges to MICRA were rejected by both the California Supreme Court and the United States Supreme Court, the Ohio Supreme Court struck down its \$250,000 limit on noneconomic damages in 1982. By 1985, Ohio's percentage of nationwide payouts had grown to 5.4%. (Figure 7)
- While a \$250,000 limit on noneconomic damages generates substantial savings, it affects very few potential claimants. The GAO found that, in 1984, only 2% of medical liability cases nationwide produced noneconomic awards over \$200,000. Yet these 2% of cases accounted for over 60% of total noneconomic payouts, demonstrating the significant cost containment function of an appropriately placed cap. (Figure 8)
- Had the California MICRA reforms been indexed to inflation, they would have failed to lower the real cost of liability insurance. A linkage to the Consumer Price Index would have doubled the limit every ten years, bringing it to over \$1 million by the

turn of the century. (Figure 9) Wisconsin abandoned its inflation-indexed ceiling on non economic damages as it appeared to be having this effect.

- While it is appropriate to link economic elements of damages to increases in medical care costs and income, it does not follow that the noneconomic losses of "suffering" or "loss of enjoyment" are in any real sense subject to inflation. Few other countries allow compensation for noneconomic damages at all, and those that do impose severe restrictions on such payments. Expressed as a percentage of gross domestic product, U.S. tort costs are more than twice that of any other developed country and four times those of the United Kingdom. Moreover, U.S. tort costs continue to grow, while that in other countries have been stable. (Figures 10 and 11)

A virtual consensus exists among physicians, other health care professionals, and institutional providers that strong traditional tort reform represents an important first step toward reaching a more rational, cost-effective means for resolving medical liability claims, regardless of whatever innovative approaches to liability reform are also advanced. The AMA strongly supports the California model of medical liability reform as a proven product that has actually decreased the real (inflation-adjusted) cost of medical liability in that state.

The Clinton Administration Plan - While the Clinton Administration's proposal for health system reform contains a number of provisions addressing medical liability reform, it fails to incorporate the major initiatives that have been successful in California for the last 15 years. For example, the Health Security Act fails to establish a ceiling on noneconomic damages, thereby preserving the incentive for plaintiffs and their attorneys to play the lottery in the courts. It also purports to restrict attorney contingency fees to 33 1/3 percent of the total amount of the judgment or settlement recovered, except where a state establishes a lower limit. But this provision represents no reform at all and merely reaffirms the status quo for the plaintiffs' bar. This provision represents virtually no limit at all, since this is the typical

share of awards now taken in the majority of liability cases handled on a contingency basis. Similarly, the periodic payment reform in the Health Security Act is strictly permissive, rather than mandatory, and, therefore, ineffective.

In fact, the \$250,000 ceiling on noneconomic damages in the California law constitutes a generous benefit, much more than any other country in the world provides. This cap, moreover, represents the most important element in containment of health care liability costs. Reducing the contingency fee as awards rise, as in MICRA, guarantees that the most seriously injured patients retain a greater percentage of the judgment, and also acts to screen out the "lottery" mentality that pervades so much of the liability environment.

While the Health Security Act permits either party to request that awards be paid in periodic installments, and also would enact a collateral source rule that reduces any recovery by amounts received from other sources, the failure to address the issues of noneconomic damages and attorney fees will do little to curtail substantial awards or the high cost of excessive and protracted litigation under a new health care system.

Alternative Dispute Resolution Systems - The AMA believes that a fault-based administrative system, such as the one designed by the AMA/Specialty Society Medical Liability Project (AMA/SSMLP), may provide a forum and process for dispute resolution that is fairer to both claimants and defendants, more cost-effective, and more systematic in deterring medical negligence and promoting patient safety than the present system. An intensive analysis of the AMA/SSMLP model completed by the Georgetown University Centers for Medicine and Law corroborates these expectations. (See Appendix C.) We

applaud the fact that experimentation with alternative dispute resolution (ADR) occupies a major role in various federal proposals advanced in the 103rd Congress, including H.R. 1625, the "Medical Malpractice Liability Reform Act of 1993," sponsored by Representative Nancy Johnson (CT), and H.R. 1572, the "Medical Care Injury Compensation Reform Act of 1993," introduced by Representative Jon Kyl (AZ). Under the Administration's proposal, patients would submit claims through an ADR established by each health plan. The AMA urges that states assume responsibility for creating ADR programs, with an impartial state authority presiding over them. We are concerned that reliance on health plans to operate ADR systems may be counterproductive as these plans could have a direct interest in the matter being considered.

The AMA strongly believes that any ADR options that are created must represent a true alternative to litigation, not a mere add-on system by any party dissatisfied with an ADR result. Unfortunately, the ADR provision outlined in the President's plan is explicitly nonbinding. Substantial experience in state forums over the past 20 years demonstrates that voluntary or nonbinding ADR options have failed to divert claims from litigation, lower transaction costs, or expedite claims resolution.

Patient Safety/Risk Management - Legislation designed to enhance patient safety must occupy a central role in medical liability reform. A number of bills introduced in the 103rd Congress would implement this approach, such as H.R. 101, the "Action Now Reform Act of 1993," introduced by Representative Robert H. Michel (IL). The AMA supports the dedication of health care professional licensing fees to increase the effectiveness of state

medical disciplinary boards. We also support the ability of states to enter into contracts with local professional societies to assist in investigating consumer complaints. The State of Maryland has implemented such a system in which local committees of physicians, operating as ad hoc agents of the state, peer review complaints, and make recommendations for action to the state licensing authority. Protected from the threat of antitrust exposure by a grant of sovereign immunity, programs such as the Maryland initiative, have the potential to significantly enhance the resources of licensing and disciplinary boards.

Efforts to involve liability insurers, hospitals, medical societies and states in risk management programs may serve to further enhance patient safety. Expansion of drug use review programs to identify patients who are overtreated or suffering ill effects from a combination of prescription drugs will also further patient safety efforts. The AMA believes that any risk management activity must be carefully undertaken so that the physician's responsibility to provide quality patient care remains paramount. Physicians must be actively involved in developing and participating in risk management activities in order to achieve the goal for which they are created -- the provision of quality patient care.

The medical profession remains committed to reducing the incidence of patient injury. In this context, we support required risk management training for health professionals and are proceeding with aggressive endeavors to restrict the ability of unethical physicians to practice medicine.

It is anticipated that federal health system reform will promote continuous quality management, as well as strengthening the current public and private systems that gather and analyze data relating to patient treatment outcomes. Identifying and measuring patient risk of

injury factors should be an important component in such outcomes analysis. Health care institutions, managed care organizations, professional societies, state licensing and disciplinary boards, and medical liability insurers all are initiating programs to promote patient safety. These approaches include risk management education, the establishment of quality standards, professional oversight and review, and disciplinary activities. Federal medical liability reform initiatives should encourage these private sector local quality management efforts.

Practice Parameters/Guidelines - At the present time, insufficient evidence exists to show that clinical practice guidelines can be developed in a manner specific enough to be introduced as an affirmative defense in medical liability litigation. Concerns arise that any governmental procedures utilized to endorse such guidelines may move too slowly to accommodate rapid changes in medical technology. If legal protection were afforded only to practices within government-approved parameters, medical treatment that embraces the newest scientific information may be discouraged.

Innovative local experiments with practice guidelines are now being tested in Maine, Minnesota, Florida, and Vermont. Physicians electing to participate in these demonstration projects will be able to assert compliance with practice parameters and risk management protocols as a legal defense in any medical liability suit brought against them during the years of the pilot programs. It is hoped that using practice parameters in this way will help to classify the standards of care applied by courts and discourage the practice of "defensive medicine" outside of approved parameters. The AMA believes that these state experiments should be supported by the federal government through the activities of the Agency for Health

Care Policy and Research. By tracking the claims brought during the demonstration period, and comparing this data with data before the experiments took effect, appropriate determinations may be made on the efficacy of using practice guidelines as an affirmative defense.

The Health Security Act would authorize the Department of Health and Human Services to develop pilot programs to test the effectiveness of applying practice guidelines in the resolution of medical liability actions. A number of other bills, including H.R. 1579, the "Managed Competition Act of 1993," sponsored by Representative Jim Cooper (D-TN) and Representative Fred Grandy (R-IA). It would award grants to states for similar demonstration projects. The AMA supports this approach.

Enterprise Liability

The concept of enterprise or "organizational" liability has garnered a great deal of attention. As originally developed by Professor Kenneth Abraham of the University of Virginia Law School and Professor Paul Weiler of Harvard Law School, the notion of enterprise liability focuses on legislatively transferring all medical liability exposure to the institution which becomes the only defendant in a liability lawsuit, with individual physicians becoming witnesses in the litigation process. In a changing health care system, medical liability exposure and quality control responsibilities would reside with accountable health plans (AHPs). Under this construct, the institution would be empowered to implement and enforce patient safety/risk management education and regulation of its medical staff.

While the AMA fully supports the goal of strengthening patient safety and risk management efforts, it remains unclear whether AHPs or other entities will be more effective in achieving it, or that this approach will benefit patients or physicians in all delivery systems. In ambulatory care settings, we believe that the physician-owned and hospital-owned liability insurance companies are presently acting as the most effective supporters of patient safety programs and that this role should not be prematurely displaced. It remains to be seen whether AHPs may be able to assume a similarly active role in the new context.

Obviously, physicians must work in a coordinated manner within health care delivery systems to promote quality. However, it is far from clear that the transfer of all responsibility and control to a health care entity with strong incentives to reduce costs will necessarily improve patient safety. The role of physicians in determining what is appropriate, quality care on behalf of their patients in an enterprise liability scheme has yet to be defined. In fact, the implementation of enterprise liability could eviscerate the important traditional function of physicians as advocates for their patients.

At its essence, enterprise liability is cost shifting, not liability reform. It may also increase the frequency and magnitude of medical liability claims as individuals become more willing to sue a new and anonymous "deep pocket." The AMA supports the objective of the current tort system in holding health care professionals to a high degree of personal responsibility for the welfare of their patients. We have long maintained that a fault-based malpractice system could serve a valuable deterrent function, as long as it is fair and cost-effective in delivering compensation to victims of negligence.

It would indeed be premature at this time to proceed with the yet untested principles underlying enterprise liability, especially when the viable California model of tort reform has actually decreased the real cost of medical liability in that state. We continue to strongly recommend that medical liability reform focus on clarifying the rules of damages and the standards of care presented in court cases, providing real access to a dispute resolution process for injured parties, and creating a workable mechanism for screening out nonmeritorious claims.

The Medical Community's Response

All parties -- patients, lawyers, physicians and insurers -- must be willing to make compromises to craft an effective solution to the medical liability problem. We agree that the responsibility is a shared one, and acknowledge that it is the provider community's particular responsibility to do whatever it can to minimize the incidence of avoidable patient injury. (See Appendix D.)

Providing medical care today involves a complex system of persons and technology, each individual and component of which is necessary to bring about the safe and effective delivery of care to the patient. All of our activities aim at the common goal of improving patient health and preventing patient injury. All call upon us to examine what we do or fail to do, and how we do it. When problems are detected, solutions are developed and implemented.

We strongly believe that the patient safety movement currently being implemented by the medical community is the optimal source of information and education for providers on

injury prevention issues. These activities are data-based, innovative and amenable to modification as new problems arise. To best prevent errors, we must study the facts of loss situations, identify high-risk circumstances, and educate physicians in a focused manner on how to avoid them.

Conclusion

Mr. Chair and Madam Chair the problems associated with excessive litigation are not new to the medical profession. The medical liability bills being considered in the 103rd Congress, the Lewin study on defensive medicine, the Harvard Medical Practice study, and virtually every other study that has been completed all validate what physicians have been saying for 15 years -- the system is broken. It needs to be fixed.

Our liability system needs to be fixed to meet the needs of the injured patients who deserve to be fairly compensated, the physicians who are willing to assume their fair share of the burden from negligent practice, and society, which needs to reduce transaction costs, eliminate windfall judgments, and assure that physicians can still offer medically necessary services in an atmosphere of fairness to all parties.

The AMA appreciates the opportunity to appear before the Subcommittees. At this time, we will be pleased to respond to questions.

Mrs. COLLINS. Mr. Cornelius?

STATEMENT OF FRANK CORNELIUS

Mr. CORNELIUS. Madam Chairwoman, members of the committee, my name is Frank Cornelius. I am from Carmel, Ind., and I would like to thank you for allowing me to be here today to address the subject of the American Health Society Act and malpractice reform.

When Indiana debated this issue back in 1975 and passed what was considered substantial legislation, one of the things we failed to do was to invite victims in. And I guess the real reason that I am here today is that as you deal with this issue I would like for you to be able to put a picture on the face, because I can sit here today and everybody can say that I look healthy and that they don't understand the problem.

This is a picture of part of my left leg. It is a problem I deal with. I have heard several times today people talking about noneconomic damages and caps of \$200,000 or \$250,000. I spent 4 years dealing with pain from what started out to be simple orthoscopic surgery which turned out to be a life-threatening disease and pain that on a scale of 1 to 10 was 10 constantly, 24 hours a day.

Last year, I had inserted in me a morphine pump which administers morphine into my lower extremities 24 hours a day and allows me to function a little better and lowers my pain to a 3 or 4. It never goes away. And to say that you can put a cap on those kind of damages, I would ask you to look at the picture, and I think it speaks for itself.

In 1975, I was a lobbyist for the insurance industry and helped pass the legislation that lowered the ability of people like myself to recover damages from malpractice acts. We combined pain and suffering, noneconomic damages all together, put a cap on it of \$500,000 and went home. As I said earlier, we never bothered to talk to someone like me.

In 1989, I had orthoscopic knee surgery. I went home. It was an out patient surgery. I went home that evening, started experiencing pain immediately, called the doctor several times that evening, couldn't get him. He finally called me back the next morning after I had called him again. He told me to stay in bed. He told me to tell my wife to get a bedpan, and that he would see me when he got back from his ski trip.

After this, this one, after he came back from his ski trip, I called him several times again and I never got an answer. A couple weeks later I went to the emergency room because my leg was swollen and I was in a lot of pain. They said that I had phlebitis and an infection, so they gave me heparin to help with the phlebitis, and since I had an infection they gave me medicine for the infection. They did get a hold of my doctor and he said he would see me Monday in the hospital.

I went into hospital that Monday, was admitted to the hospital and stayed for 10 days to fight blood clots and an infection. Towards the end of my stay, as I would get out of bed to take a shower or to get cleaned up, I noticed every time I put my leg down it turned blue. It would start swelling up right away. So I asked for

my orthopedic doctor to come back in, because he had turned me over to an internal medicine doctor.

I finally got down to the place where I said I wasn't going to leave the hospital until he came in, and I can remember now, as he walked in the room and sat down and said, "Frank, what's the problem?" And I tried to tell him and he said, "Frank, go home. We are going to start you on physical therapy. You don't have a problem."

I will make this short because I know my time is running out, but I went from there to a physical therapist who treated me a couple times and then said she wouldn't treat me anymore. I went back to my home. I tried to reach my doctor, couldn't. I finally wound up with the internal doctor who recommended that I see another orthopedic surgeon. When I saw him he recognized through tests and through examining my leg that I have a disease called reflex sympathetic dystrophy.

He immediately started me on a program to get this under control. We started doing that and we were successful until a physical therapist hit me with a tens unit and a lot of electricity.

I was told my time of 5 minutes would go rather fast.

I ask you to look at this and I ask you to consider that there are people out there that need your help, and that the cry of everything can be controlled by putting caps on damages is a false solution.

Thank you.

[The prepared statement and attachments of Mr. Cornelius follow:]

**TESTIMONY OF
FRANK CORNELIUS**

Chairman Waxman, Chairman Collins, Members of the Subcommittees, I am Frank Cornelius from Carmel, Indiana. Thank you for allowing me to testify today on President Clinton's proposed health care reform package, the American Health Security Act, and specifically the provisions that deal with medical malpractice. When Indiana debated medical malpractice reform in 1975, no one took the time to listen to the victims of medical negligence. I have traveled to Washington so that you may put a human face on this issue. My testimony will focus on my experiences as a victim of negligent medical care, the effect of Indiana's so-called "reforms," and my concerns about some of the medical malpractice provisions in the Clinton plan.

In 1975, I was a lobbyist for Indiana insurers who were fighting to enact caps on medical malpractice awards for noneconomic damages such as pain and suffering and awards for economic damages. I argued then that damage caps would lower health care costs, keep doctors' malpractice premiums low and encourage physicians to stay in Indiana. Unfortunately, these arguments swayed legislators and damage caps were enacted in Indiana. The false arguments that insurers and the medical industry used then are the same ones that underpin the medical industry's call for national malpractice reform now.

While lobbying for insurers, I certainly could not foresee the cruel twist of fate that lurked in my future. In 1989, I was seriously injured by negligent medical care. After suffering a minor knee injury, I was operated upon by an orthopedic surgeon. I continued to experience a lot of pain the day I left the hospital and called the surgeon several times that evening. He finally returned my calls the next day, ordered me to stay in bed and told my wife to get me a bedpan. He then left on a ski trip. I was forced to seek out another surgeon

who immediately diagnosed the problem as Reflex Sympathetic Dystrophy.

A few months later, my physical therapist failed to read the instructions on a medical device correctly. As a result, the device gave me a tremendous current of electricity through my left leg. This seriously complicated my condition. Another time a doctor decided the next medical step without ever having seen me, which again complicated my condition. In August 1990, another physician proposed a medical procedure, but failed to secure the necessary instruments. This doctor then proceeded with a different device that left me with several holes in my venacava, which is the main vein from a human's legs to the heart.

The doctor sent me back to my room. I began to bleed to death, and if my wife had not returned to the hospital that evening, I could have died. As another physician tried to save my life, he punctured my left lung. I was soon moved to a second hospital in Indianapolis, where my condition was diagnosed. It was determined at this hospital that, if I was to live, I would require surgery. However, the second hospital would not permit the surgery to occur there because it feared that I might die on the operating table. It was necessary for my wife of six months to make life and death decisions -- decisions she should never have been called upon to make.

As a result of this medical debacle, which began with a simple knee injury and surgery, I must use a wheelchair. I have incurred continual medical expenses and have not been able to work. Twice during this time, I have received last rites from my church.

My attorney has filed a medical malpractice lawsuit on my behalf for the August 1990 incident, but my claim has not been acted upon by the medical review panel that certifies such claims in Indiana. A separate claim against the hospital and physical therapist has been

settled. Meanwhile, Medicare pays little or nothing. On a more personal note, my wife and I are splitting up, which I believe is attributable in part to the predicament that negligent medical care has put me in. I am currently insured under my wife's plan, but that will be discontinued should we be divorced. The emotional fallout on our five children has been, to say the least, difficult to witness.

INDIANA'S FAILED 'REFORMS'

The truth is that so-called medical malpractice "reforms," including caps on economic and noneconomic damages, have done nothing to control health care spending in Indiana. The public interest group Families USA Foundation reported that Indiana's health care costs increased 139.4 percent between 1980 and 1990. This increase is even higher than the national average of 138.7 percent.

According to the consulting firm Lewin/ICP, Indiana ranked 32nd in per capita health care spending among states in 1980 -- the exact same position it occupied in 1990. As these studies show, the reforms enacted in Indiana have done nothing to curb health care spending.

It is understandable that the reforms enacted in my state have done little to curb health care spending since such reforms and spending are unrelated. The Congressional Budget Office last year reported that medical malpractice litigation accounts for less than 1 percent of total health care spending. I doubt that the percentage in Indiana is much different. Clearly, damage caps and other reforms have not controlled health care spending in Indiana. What these measures have done is provide special treatment to one group -- the medical

industry.

Nevertheless, proponents of Indiana's reforms argue that doctors in the state pay less for malpractice insurance than doctors in other states. This is true, but it is only half of the story. Malpractice premiums in Indiana are artificially low because insurers only write up to \$100,000 of coverage. Negligently injured patients who are entitled to more than \$100,000 must look to Indiana's state-run excess compensation fund. Depending on when the malpractice occurred, the patient can receive up to an additional \$400,000 or \$650,000 in compensation. The excess compensation, however, comes from a surcharge on Indiana doctors. Consequently, doctors' true malpractice costs are not accurately reflected unless malpractice premiums and surcharges are added together. It is noteworthy that the surcharges have ballooned from 10 percent in 1975 to 125 percent in 1990.

In addition, doctors have not flocked to my state because of damage caps and apparently low insurance premiums. The 1991 Statistical Abstract of the United States reports that Indiana has 45 fewer physicians per 100,000 residents than the national average. Further, the Indiana Medical Association states that half of all graduates of the Indiana University School of Medicine leave the state upon graduation.

MY CONCERNS

I am concerned that some of the measures included in the proposed health plan will delay compensation to people who have been injured by medical negligence and preclude others from bringing meritorious claims. This is particularly worrisome since, as a Harvard University study concluded in 1990, there are far more people injured by medical negligence

than ever bring claims.

I fear that alternative dispute resolution will become a vehicle for delaying compensation to negligently injured patients. ADR will add another layer of bureaucracy for people like myself to go through. I do not believe ADR will encourage early offers of settlement. It is noteworthy that several states, including New York, that have tried ADR have discontinued it.

I also believe medical certification of claims is unnecessary and harmful to patients' rights. The medical profession, like other professions, is a fraternity. It is too much to expect doctors to certify claims against their colleagues. Medical certification also will delay compensation to those who are injured. My experience with Indiana's certification panel is telling. I was injured in 1989 and the panel has yet to consider my claim. Ironically, if Indiana's reforms had worked and reduced the number of claims, the medical review panel should have more time to review claims. Obviously, this is not the case.

The proposed cap on attorney fees simply is not relevant to efforts to control health care costs and reducing medical negligence. Capping attorneys fees may discourage some lawyers from taking cases. However, the truth is that such caps will give defendants an unfair advantage because defendants will be able to spend unlimited amounts on legal representation. This is not just. Furthermore, why should the government become involving in regulating a private contract between plaintiffs like myself and attorneys.

In conclusion, to say that we can lower health care costs by capping damages or attorney fees only appeals to those with no knowledge of the civil justice system or America's way of life. The civil justice system is the only effective tool for holding the medical industry accountable for its negligence. Doctors have not been able to police their own.

I am told by physicians that my life expectancy is less than two years. I plan to spend my time fighting for just compensation for those who have been injured by medical negligence. I also would like to help you through the minefield of half-truths, scare tactics and outright lies that have been perpetuated by the those who seek to limit the rights of the negligently injured. Together, I feel, we can make a difference.







Mrs. COLLINS. Ms. Gilbert?

STATEMENT OF PAMELA GILBERT

Ms. GILBERT. Thank you, Chairwoman Collins.

I am Pamela Gilbert. I am the Director of Public Citizens' Congress Watch. Public Citizen is a consumer organization that was founded by Ralph Nader, and Congress Watch is its lobbying arm.

In addition to my written testimony, I have two reports I would like to submit for the record.

Mrs. COLLINS. Without objection.

Ms. GILBERT. Thank you very much.

I very much appreciate the opportunity to be here to present our strong view that restricting the rights of victims of medical malpractice will not reduce the cost of health care or medical malpractice insurance. It will be detrimental to efforts to improve the quality of health care, and it will penalize some of the most vulnerable members of the community, those who have been victimized by negligent medical care.

We are bitterly disappointed that almost every health care plan that has been introduced in Congress this year does contain restrictions on victims' legal rights. The single-payer bills introduced in the House by Representatives McDermott and Conyers, and co-sponsored by you, Chairwoman Collins, are the only bills that do not include restrictions on legal rights, but they have been introduced without them and that was misrepresented earlier today. That there were no bills.

There is a medical malpractice crisis in this country, but that crisis is not in the courtroom. It is in doctors' offices and it is in hospitals. Public Citizen estimates that between 150,000 and 300,000 people are killed or injured by medical negligence every year.

Extrapolating from results from the Harvard study that I think Mr. Brennan is going to talk about, 80,000 people are killed every year from medical negligence. That is more than twice the number that are killed on the highways every year and more than the number that die of gunshot wounds. Yet, most attempts to address this problem have embodied a tax on victims and their right to recover damages, not on solving the problem, which is ensuring quality care and eliminating medical negligence.

Frank Cornelius and Laura Wittkin are here today to talk to you about the problems victims face in the system and why national health care reform is the ideal opportunity and is critical to be used for malpractice prevention and easing the burden on victims.

What I am going to talk about is to refute some of the myths that have been talked about this morning and have been spread in this town for many, many years about the malpractice liability system.

First of all, limiting legal rights will not lower health care costs. Medical malpractice costs are a minuscule portion of total health care costs.

According to a recent report by the national insurance consumer organization, total medical malpractice insurance premiums paid by doctors and hospitals in 1992 were \$4.1 billion, while total health care costs were \$838.5 billion. That means that medical

malpractice insurance premiums were about 0.5 percent of total health care costs.

Additionally, that number has stayed stable since 1987. In 1987, insurance premiums were \$4 billion. In 1992, they were \$4.1 billion.

Additionally, malpractice insurance premiums are a small part of most doctors' expenses. According to the AMA's own figures, in 1989 professional liability insurance premiums were only 4.9 percent of revenues for the typical physician in practice.

Second, limiting legal rights will not increase access to medical care. Out of the 15 States that have the highest number of doctors per hundred thousand people, only 5 have enacted liability restrictions similar to the AMA backed plan. I will note that the District of Columbia is number 1 for number of physicians per hundred thousand people, while we have no tort restrictions in the District of Columbia.

Between 1980 and 1990, 4 out of the 5 States that had restricted their liability went down in the rankings for number of doctors, while 5 out of the 10 with no restrictions had gone up.

Finally, to deal with the OB-GYN issue, the New York State Education Department conducted an independent 10-year study of obstetricians in New York. They found that only 5 percent of obstetricians in the State discontinued their practice or changed their practice specialty between 1980 and 1990 and that rate was no different from other practice specialties.

Finally, I want to also reiterate that limiting legal rights is not the answer to defensive medicine either. I was happy to see that Dr. Painter used a much more rational figure about the cost of defensive medicine. If they are all caused by the liability system, and there has been no evidence, Dr. Painter said \$35.8 billion in 5 years. If that is the case, that is about \$7 billion per year. If you combine that even with malpractice insurance you still have less than 2 percent of the cost even related to the liability system, let alone whether they would be lessened by restricting a liability system.

Mrs. COLLINS. Ms. Gilbert, your time has expired.

Ms. GILBERT. I know. Thank you.

[Testimony resumes on p. 402.]

[The prepared statement of Ms. Gilbert follows. The attachments referred to are retained in subcommittee files.]

Testimony of
Pamela Gilbert
Director
Public Citizen's Congress Watch

I am Pamela Gilbert, director of Public Citizen's Congress Watch. Public Citizen, with over 160,000 members nationwide, is a consumer organization founded by Ralph Nader. Congress Watch is the lobbying arm of Public Citizen. Public Citizen has long been active in efforts to reform the nation's health care system and to improve the quality of medical care. I appreciate the opportunity to present our strong view that restricting the rights of victims of medical malpractice will not significantly reduce the costs of health care or medical malpractice insurance, will be detrimental to efforts to improve the quality of health care, and will penalize some of the most vulnerable members of our community -- those who have been victimized by negligent medical care. We are bitterly disappointed that almost every health care plan that has been introduced in Congress this year, including the President's, contains restrictions on victims' legal rights. The single-payer bills, introduced in the House by Representatives McDermott and Conyers, and cosponsored by Chairwoman Collins, and in the Senate by Senator Wellstone, are the only proposals that do not penalize injured victims.

INTRODUCTION

There is a virtual epidemic of medical malpractice in this country. Public Citizen estimates that between 150,000 to 300,000 Americans are injured or killed each year by doctor negligence. Extrapolating from a study conducted by Harvard Medical School, approximately 80,000 deaths occur annually due to doctor negligence -- more than twice the number of motor vehicle occupants killed each year. Yet, most attempts to address the problem of medical malpractice have been embodied in attacks on victims and their right to recover damages from negligent providers, not on solving the problem at the source -- ensuring quality care and

eliminating medical negligence.

Now, the American Medical Association and its lobbyists want to use the current efforts to address the national health care crisis as a vehicle for the same shop-worn proposals to restrict the legal rights of victims that the medical society has been pushing for two decades. They claim that limiting victims' rights is a solution to the skyrocketing costs of the health care system. Nothing could be further from the truth. In fact, medical malpractice costs make up a minuscule part of overall health care costs. Even if we completely eliminated the right of victims of medical negligence to recover for their losses, we would make barely a dent in the costs of the health care system, if in fact those costs would be reduced at all.

The greatest impact of restricting access to the courts would be felt by the victim of negligent care who might receive little or no compensation. In addition, relieving negligent doctors of responsibility for paying for the costs of their victims' injuries does not mean that these costs would disappear. Someone would have to pay for those injuries, whether it is the victims themselves or taxpayer-financed programs. This would not save the country health care costs, it would simply shift those costs from the wrongdoers to the national health care system and taxpayers. This cost-shifting is antithetical to the cost-cutting goal of national health care reform. Finally, reducing victims' rights could even increase the overall costs of the health care system by decreasing the deterrent effects of the system. Reducing deterrence would likely lead to more injuries from malpractice, and hence, higher health care costs.

It is, frankly, shocking that the health care plans introduced to date have no response to the medical malpractice crisis other than to punish its innocent victims. The purpose of physician

licensing is not to bestow on them a privilege, but rather, to provide a mechanism to protect the public. National health care reform must include provisions to ensure that, in return for that license, each physician provides a minimum standard of care.

It is equally an insult to the tens of millions of uninsured and underinsured Americans to suggest that any part of the solution to the unavailability of affordable health care is to take away compensation from people who have been injured by careless doctors. Rather than enacting proposals to restrict the legal rights of U.S. residents, the national health care debate should focus, instead, on providing adequate health insurance and ensuring high quality care for all. In fact, by ensuring access to health care for everyone, we would do more to reduce the number of malpractice lawsuits than restricting legal rights could ever accomplish. After all, if an injured person's medical bills are paid for, there would be little incentive to bring a lawsuit to collect compensation. A recent study of liability law and compensation in 10 countries conducted by the Insurance Information Institute, an insurance industry-funded research organization, concluded that other countries have far fewer personal injury lawsuits than the U.S. largely because those countries have a much greater availability of government entitlement programs, including national health care and more expansive workers' compensation systems.

The United States has the resources to provide comprehensive, high quality health care to all its residents and to adequately compensate the unfortunate victims of medical malpractice. Public Citizen believes that a single-payer health care program similar to the Canadian system could provide universal health care in the U.S. for the same cost as our current inadequate system, without curbing the rights of malpractice victims. The solution to the serious problem of malpractice, on the other hand, is to prevent the injuries in the first place through improved

physician oversight and discipline, better training, and by opening up the National Practitioners' Data Bank for use by the public.

THE PROBLEM OF MEDICAL NEGLIGENCE

Medical negligence occurs too frequently.

More people die due to medical negligence than die on the highways or of gunshot wounds every year. According to a 1991 Physician Payment Review Commission report: "the evidence is compelling that rates of inpatient medical injury and negligent medical injury are substantial."¹ Public Citizen estimates that between 150,000 and 300,000 Americans are injured or killed each year by doctor negligence, based on the results of three studies of hospital patients:

The 1991 Harvard Medical Practice Study of New York hospitals found that medical negligence caused one percent of hospital patients to suffer an injury which prolonged their hospital stay.² Using this figure and extrapolating to all admissions in New York State in 1984, according to the study, negligence of doctors or hospital staff contributed to approximately 4,000 hospital deaths and an additional 23,000 injuries. Applying these figures nationwide would mean that in 1988, 234,000 injuries and 80,000 deaths were caused by negligence in American hospitals. This is more than twice the number of fatalities of motor vehicle occupants occurring each year.

¹ Physician Payment Review Commission: Annual Report to Congress, 1991, p. 364.

² Brennan, Troyen and others, "Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I," New England Journal of Medicine, February 7, 1991.

Similarly, a study of hospital inpatient records in California found that 0.8 percent of patients were injured by medical negligence in 1974.³ Extrapolation of those findings yields an estimate of 249,000 injuries and deaths from negligence in 1988.

In 1976, the Department of Health, Education and Welfare's Malpractice Commission estimated that one-half of one percent of all patients entering hospitals are injured there due to negligence.⁴ That estimate would indicate 156,000 such injuries and deaths resulted from doctor negligence in 1988.

Furthermore, the RAND Corporation studied records of 182 patients who died in hospitals in 1985.⁵ Three independent physicians reviewed the files and found 14 - 27 percent of the deaths were probably preventable. The study also found evidence that "a small number of factors caused most preventable deaths. In fact, nine reasons encompassed all of the issues identified by the physician panel."

As troubling as these findings are, the studies actually underestimate the rate of medical malpractice. First, the studies do not include death and injury from negligence that occurs outside a hospital setting. Second, the findings include only incidents of negligence that actually result in injury. The studies do not measure the occurrences of substandard care that have the potential to produce injury but, fortunately, do not result in injury.

The medical malpractice system helps to compensate many victims of malpractice and to

³ Mills, Don, ed., Report on the Medical Insurance Feasibility Study (San Francisco: California Medical Association and California Hospital Association, 1977).

⁴ Journal of Legal Medicine, February, 1976.

⁵ Danzon, Patricia, "The Frequency and Severity of Medical Malpractice Claims: New Evidence," Law and Contemporary Problems, 1986.

send a message of deterrence to care providers. But clearly, more needs to be done to prevent death and injury from negligent care.

Doctor discipline programs must be improved.

Improvements in disciplinary programs against doctors who commit malpractice could prevent a substantial number of incidents of malpractice. This is especially true because, according to a number of studies conducted in the past ten years, a small number of physicians are responsible for most medical malpractice claims. Therefore, by reducing incidents of negligence by those few doctors, most malpractice injury can be avoided.

The following brief review of some of these studies shows the extent to which a small percentage of doctors cause the majority of malpractice injuries:

- * In Florida, 3 percent of doctors accounted for 45 percent of the claims paid during the years 1975-1984.⁶ Another Florida study found that, between 1975 and 1980, 3 percent of medical specialty physicians accounted for more than 85 percent of that group's payments; 6 percent of obstetrics-anesthesiology physicians accounted for more than 85 percent of that group's payments; and 7.8 percent of the surgical physicians accounted for 75 percent of that group's payments.⁷
- * In Los Angeles, 0.6 percent of doctors in a four-year period accounted for 10 percent of all claims and 30 percent of all payments.⁸
- * A 1991 study of physicians covered by the primary physician-owned insurer in Tennessee found "a disproportionately small number of doctors are responsible for a

⁶ "Medicine On Trial: The Malpractice Crisis," Orlando Sentinel, series beginning April 13, 1986.

⁷ Sloan, et.al., Medical Malpractice Experience of Physicians: Predictable or Haphazard?, 262 J.A.M.A., 1989.

⁸ Schwartz & Komesar, Doctors, Damages and Deterrence, 298 New Eng. J. Med., 1987.

disproportionately large frequency and severity of lawsuits."⁹

- * In Pennsylvania, one percent of physicians accounted for 25 percent of losses paid over a ten year period.¹⁰
- * A 1987 study of Cook County, Illinois found two percent of all physicians practicing in the county were defendants in 36 percent of all medical negligent litigation filed since 1973.¹¹
- * A 1987 Public Citizen study found that "7.5 percent of all practicing physicians in Texas are responsible for 65 percent of the reported claims filed between 1978-1984".¹²

An increase in disciplinary actions against these recidivist doctors would substantially decrease the incidence of malpractice across the country. However, evidence compiled by the Public Citizen Health Research Group shows that, in general, negligent and incompetent doctors are rarely disciplined or removed from practice. According to the report "Comparing State Medical Boards," published by the Health Research Group, at most, about 0.5 percent of the nation's doctors face any sanctions at all from their state medical boards each year. The report found that in 1991, only 3.44 serious disciplinary actions (license revocations or suspensions, probation, surrender of license, loss of privileges, and limitations or restrictions of privileges)

⁹ Schmidt, Windsor C., et.al., "Factors Associated with Medical Malpractice: Result from a Pilot Study", The Journal of Contemporary Health Law and Policy, Volume 7, Catholic University of America, 1991.

¹⁰ Hofflander and Nye, "Medical Malpractice Insurance in Pennsylvania," Management Analysis Center, 1985.

¹¹ Miller, Natalie, et.al., "Medical Malpractice: Crisis of Litigation or Crisis of Negligence?" Health Resources Inc., 1987.

¹² "Medical Malpractice in Texas: Are We Covering Up the Symptoms Instead of Curing the Disease?" Public Citizen, compiled from reports by the Texas State Board of Medical Examiners, 1987.

were taken per 1,000 physicians nationwide.¹³ This is equivalent to 2,013 such actions in all of 1991 -- a pittance compared to the 150,000 - 300,000 who are injured or killed each year in hospitals as a result of medical negligence. (I would like to submit this report for the record of today's hearing.)

What is more, according to another report by the Health Research Group, 10,289 Questionable Doctors, the number of serious disciplinary actions taken by state medical boards decreased between 1991 and 1992. In addition, in cases of negligent, substandard or incompetent care, 69.9 percent of physicians were given sanctions that allowed them to continue practicing, and about which most of their patients were unaware. At a minimum, the public must be made aware of doctors who have been sanctioned for negligence or incompetence so consumers can protect themselves by avoiding those doctors, or paying particularly close attention to the quality of care they receive from those providers.

In general, the types of actions taken by state licensing boards do not address the issue of poor quality care due to medical negligence. Instead, most states focus attention on physicians with drug and alcohol problems, occurrences that are easier to define and identify than incidents of negligent conduct. The fact that most states fail to exert the maximum possible effort to discipline negligent doctors is one of the most serious threats to the health of American patients, and a major reason why the legal system is so important as an adjunct to state regulatory actions.

¹³ VanTuinen, Ingrid, McCarthy, Phyllis, Wolfe, M.D., Sidney M. and Barne, Alana, "Comparing State Medical Boards," Public Citizen Health Research Group, January, 1993.

RESTRICTING VICTIMS' RIGHTS WON'T HELP THE HEALTH CARE CRISIS

Limiting legal rights will not lower health care costs.

The U.S. health care system is failing fast. The U.S. spent \$838.5 billion on health care in 1992, and without significant reform, that figure is expected to exceed \$1 trillion by 1994. This represents nearly 14 percent of the gross national product, up from 11.6 percent in 1989. Despite these massive expenditures, the U.S. ranks 12th worldwide in life expectancy; 21st in the number of deaths of children under age 5; and 22nd in infant mortality. Furthermore, between 37 million and 48 million Americans have no health insurance at all.

In order to avert disaster, this nation must reduce health care costs. Studies by the U.S. General Accounting Office, Physicians for a National Health Program, and Public Citizen show a potential savings in administrative costs between \$60 and \$135 billion if the U.S. adopts a single-payer health care plan similar to the system in Canada. By redirecting this wasteful administrative spending to health care, the U.S. could provide universal coverage for all Americans without spending more money on health care than we do today.

Rather than endorse this sensible and humane program, the American Medical Association claims that placing restrictions on victims' rights will lower costs and increase access to health care. Even if this were true, it would be unfair and cruel to cure the problems in the health care system on the backs of injured victims. In fact, however, limiting legal rights will not result in a cost savings in the health care system.

Medical malpractice costs are a minuscule fraction of overall health care costs. According to a report by the National Insurance Consumer Organization, in 1992, total medical malpractice insurance premiums paid by doctors and hospitals were \$4.1 billion, while total health care costs

were \$838.5 billion.¹⁴ This means that medical malpractice premiums in 1992 represented less than 0.5 percent of total health care costs. Contrast this with the administrative costs of the system, estimated to range from 10 percent to 25 percent of health care costs, or with doctors' income, estimated to make up about 15 percent of total costs. Furthermore, malpractice premiums have remained stable for the last six years, going from \$4.0 billion in 1987 to \$4.1 billion in 1992. In contrast, national health expenditures increased 52.9 percent in that same time period.¹⁵

Malpractice premiums also make up only a small part of most doctors' expenses. According to American Medical Association figures, in 1989, professional liability insurance premiums accounted for only 4.9 percent of revenues for the typical physician practice.¹⁶ The largest expense was for nonphysician employee wages. That same year, the nation's largest medical malpractice insurer lowered its rates in 34 states.¹⁷ And while insurance rates decreased in 1989, the average income of physicians increased by almost 8 percent that year, far more than the 4.6 percent rate of inflation. The increase brought doctors' incomes to \$155,000, an increase of \$11,100 over 1988.¹⁸ The high cost of health care cannot be blamed on the small costs of

¹⁴ "Medical Malpractice Insurance 1985-1991 Calendar Year Experience," National Insurance Consumer Organization, March, 1993.

¹⁵ "Analysis of 1992 Commerce Department Health Expenditure Data," Public Citizen Health Research Group, December 29, 1992.

¹⁶ Gonzalez, Martin L., Socioeconomic Characteristics of Medical Practice 1990/1991, American Medical Association, p.22.

¹⁷ "Biggest Malpractice Insurer Cuts Rates in 34 States," Liability Week, Volume 4, No. 16, April 17, 1989.

¹⁸ "Doctors' Average Income Reaches \$155,000," Federal and State Insurance Week, December 14, 1990.

protecting victims from negligent physicians.

Finally, the medical malpractice system may actually save money in the health care system because of its deterrent effect. According to Patricia Danzon of the Wharton School, "...if the number of negligent injuries is, generously, 20 percent lower than it otherwise would be because of the incentives for care created by the malpractice system, the system is worth retaining, despite its costs."¹⁹

Limiting legal rights will not increase access to medical care.

The AMA claims that the medical malpractice system is driving doctors from the profession, limiting access to medical services for consumers. In particular, they claim that specialists, such as obstetrician/gynecologists, are leaving their specialties because of lawsuits. The facts do not support these claims.

Out of the 15 states that have the highest number of doctors per 100,000 people, only 5 have enacted liability restrictions similar to the AMA-backed plan -- Maryland, California, Hawaii, Florida and Minnesota. Between 1980 and 1990, 4 out of these 5 went down in their ranking for number of doctors per 100,000 people as compared to the rest of the country -- only Maryland did not go down, but stayed the same at number 3. In contrast, five out of the ten states without liability restrictions went up in the rankings.²⁰ (See Table 1 in appendix) Clearly, where states have placed limits on legal rights, the number of doctors practicing has not

¹⁹ Danzon, Patricia M., Medical Malpractice: Theory, Evidence, and Public Policy, Harvard University Press, 1985.

²⁰ Physician Characteristics and Distribution in the U.S., American Medical Association, Chicago, Illinois, 1981 and 1992 editions.

increased.

A close look at two jurisdictions with very different medical malpractice rules -- California and the District of Columbia -- further illustrates this point. In 1990, Washington, DC, which has never limited medical malpractice laws, had the highest per capita ratio in the nation, with 658 doctors for every 100,000 people. In 1980, the District also ranked first, with 576 doctors per 100,000 people. California, which adopted the AMA's wish list of liability rules in 1975, ranked 8th in the country with only 272 doctors per 100,000 people in 1990. In 1980, California ranked 6th in the country, with 248 doctors per 100,000 people -- a drop in the rankings of 2 within 10 years.²¹

A similar examination of the numbers of practicing obstetrician/gynecologists produces similar results. In New York State, which has not adopted the AMA plan, the number of ob/gyns increased 19.9 percent between 1980 and 1990, while the population increase by 2.1 percent. During that same period, the number of ob/gyns in California increased 34.9 percent, while the population increased by 22.4 percent.²² If California had the same rate of increase as New York per population, its number of ob/gyns would have increased 212 percent.

The New York State Education Department conducted a ten-year study of obstetricians in New York. The study found that only 5 percent, or one out of 20, obstetricians in the state discontinued their practice or changed their practice specialty between 1980 and 1990. This

²¹ Ibid.

²² Ibid.

drop-out rate was no different than other practice specialties.²³ The reasons obstetricians cited for changing their practice:

- * long, unpredictable hours;
- * burn-out; and
- * dissatisfaction with working conditions.

Injured victims rarely bring lawsuits.

It is not surprising that malpractice costs make up a small portion of health care costs, since, on the whole, Americans rarely use the courts for accident compensation. According to a 1991 RAND study, only 3 percent of seriously injured victims involved in accidents not related to the workplace or automobiles file a liability claim.²⁴ An earlier Rand study concluded, "At most, one in ten incidents of medical malpractice results in a claim, and of these, less than half, or one in 25 receive payment."²⁵ Similarly, the 1991 Harvard Medical Practice study estimated that in 1984, only one out of eight negligently injured patients filed a claim to recover damages.²⁶ The study further found that 16 times as many patients suffered an injury from

²³ "Physician Supply and Characteristics in New York State 1980-1990," the State Education Department, Bureau of Post Secondary Research & Information."

²⁴ Hensler, Deborah R., et.al., Compensation for Accidental Injuries in the United States, Rand Corporation, Institute for Civil Justice, 1991.

²⁵ Economic Analysis of the Medical Malpractice System, the Rand Corporation, 1983.

²⁶ Brennan, Troyen, et.al., "Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I," New England Journal of Medicine 324:370-6, 1991.

medical negligence as there were patients who received compensation from the medical malpractice system. The study concluded, "Our problem is not a litigation surplus, but a litigation deficit. The gap between torts occurring in American hospitals and torts being filed in American courts is far greater than has ever been supposed."

Likewise, a 1991 study by a committee within the American Law Institute states: "Deserving victims with legitimate claims continue to face high barriers to obtaining tort redress."²⁷ In short, few victims of malpractice ever bring a liability claim, and even fewer receive compensation through the legal system. If any changes are made to the malpractice system, therefore, the modifications should seek to open up the system to more claims, not to make it even more difficult to bring successful lawsuits.

Juries are not biased toward plaintiffs, and jury awards are not excessive.

Supporters of placing caps on damage awards and other limits on the malpractice system often claim that these reforms are necessary because juries tend to award high verdicts to sympathetic plaintiffs. Once again, the evidence shows otherwise.

Duke University Law School's Medical Malpractice Project recently completed a study which attempted to review every malpractice suit filed in North Carolina between July 1, 1984 and June 30, 1987 -- 895 cases. The project also collected information on more than 300 other cases filed in a sample of North Carolina counties between July, 1987 and December, 1990. The

²⁷ "Reporters' Study on Enterprise Responsibility for Personal Injury," Approaches to Legal and Institutional Change, Volume II, The American Law Institute, 1991 ("...the views in the Reporters' Study have not been considered by the membership and do not represent the position of the Institute...").

study found that medical malpractice juries are not consistently pro-plaintiff, nor do they award excessive damages.²⁸

According to the study, about 40 percent of the cases reviewed were terminated without any payment to the plaintiff, and about 50 percent were settled. Only about 10 percent of the cases, or 117 cases, were decided by a jury.

Out of the 117 cases that went to trial, there were only four large jury awards, ranging in size from \$750,000 to \$3.5 million (subsequently reduced to \$2.9 million). These judgments were awarded in cases involving severe brain damage, permanent paralysis and brain damage, death from suffocation by an intubation tube improperly placed, and a child who suffered brain damage at birth. The study found that the average damage award in cases that plaintiffs won was \$367,737. But this number was much inflated by the four large awards discussed above. The median or mid-point award, on the other hand, was only \$36,500.

The Duke study also found that juries are not biased in favor of injured patients. In the cases that went before a jury, the plaintiff prevailed in just one out of five. Furthermore, the juries found in favor of defendants in 18 out of 19 cases that insurers expected to win, and 13 out of 17 cases that insurers rated as questionable. And juries even ruled against plaintiffs in a majority of cases -- six out of 11 -- that insurers thought they would lose.²⁹

A group of researchers evaluated over 8,000 medical malpractice cases filed in New Jersey between 1977 and 1992 and made a similar finding: "unjustified payments in medical

²⁸ "The Unfair Criticism of Medical Malpractice Juries," Neil Vidmar, Judicature, October/November, 1992.

²⁹ "Still Warring Over Medical Malpractice," Kenneth Jost, ABA Journal, May, 1993.

malpractice cases are probably uncommon."³⁰ The study found that, out of the 976 cases that went to trial, plaintiffs prevailed only 24 percent of the time. Furthermore, payments were made in 91 percent of the cases where the doctor's conduct was deemed indefensible by the insurance company, and in 59 percent of the cases where the conduct was deemed unclear. Plaintiffs received payment in only 21 percent of the cases where the insurers deemed the doctor's behavior defensible. But the authors of the study noted that some of those payments were also justified, because evidence of the doctor's mistakes came out during the course of the case, after the insurance company had reviewed it.

Other studies have come to similar conclusions. A U.S. General Accounting Office study found that the median malpractice payment in 1984 was \$18,000, and that 69 percent of victims received less than \$50,000.³¹ Furthermore, the study found that any increases in settlements could be attributed to the rise in health care costs. According to the report, between 1981 and 1984, the average malpractice verdict increased at an annual rate of 3.9 percent, yet health care costs increased 11.8 percent.

In summary, malpractice insurance premiums represent less than one percent of the nation's health care bill. Experience shows that enacting liability restrictions does not increase the number of doctors practicing medicine. This is not surprising since fewer than ten percent of malpractice victims ever even bring a liability claim to recover their losses, and only a fraction of these claims are successful. Furthermore, jury awards and settlements in malpractice cases

³⁰ "The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims," Taragin, MD, MPH, Mark I., et.al., Annals of Internal Medicine, 1992;117:780-784.

³¹ U.S. General Accounting Office, Medical Malpractice: Characteristics of Claims Closed in 1984, April, 1989.

are not excessive, are not increasing at a high rate, and juries generally find for defendants when physician's care has met expected standards.

Finally, it has been estimated that the malpractice system helps reduce malpractice costs by about 10 percent because of the incentives in the system that prevent malpractice from occurring.³² Therefore, restricting the medical malpractice system could increase overall costs by reducing these incentives and increasing the incidence of malpractice. And it must be remembered that placing limits on victims' rights to recover from negligent doctors will not eliminate those costs. Restricting victims' legal rights will merely shift the costs of malpractice to the health care system and to taxpayers.

DEFENSIVE MEDICINE

"Defensive medicine" has never been objectively defined or quantified, and its causes have not been identified.

Advocates of limiting victims' rights to sue argue that it is not just insurance premiums that make the medical malpractice system expensive. They claim that "defensive medicine" -- medical practices that are not in the best interest of the patient, but are performed to avoid liability -- is driving up health care costs. But even the AMA's own sources admit that it is virtually impossible to measure the amount of "defensive medicine" that exists, or to precisely identify its cause. So-called "defensive medicine" may simply be good, careful medicine. In addition, much care labeled "defensive medicine" may be the result of physician self-dealing -- profitable referrals for testing at facilities in which the doctor has a financial stake.

³² Hofflander, Alfred E. and Nye, Blaine R., "Medical Malpractice in Pennsylvania," Management Analysis Center, Inc., 1985, p.xxiii.

Moreover, there is no evidence that performing unnecessary tests and extra procedures will prevent doctors from being successfully sued for malpractice. In fact, it will probably increase their chances of a lawsuit. First, performing unwarranted medical procedures is itself a form of medical malpractice. Second, medical malpractice lawsuits are most often brought because of adverse outcomes from a procedure that was performed, rather than because a doctor failed to take a particular action. Finally, a recent survey of doctors who have never been sued concluded that forging a strong doctor-patient relationship is the best way to avoid a malpractice action.³³

In 1990, the Texas Medical Association invited doctors who had practiced at least 20 years without a malpractice lawsuit to explain how they handle their relationships with their patients. Over 200 doctors responded, and almost all of them focused on improving communication with patients as the key to avoiding lawsuits. The doctors made the following recommendations to avoid being sued:

- * Develop close and friendly relationships with patients;
- * Respect the patient's dignity;
- * Respect the patient's privacy;
- * Listen patiently;
- * Be available and return phone calls promptly;
- * Be polite;
- * Be on time;
- * Keep patients' expectations in line, prepare them for any eventuality;
- * Have the patient join in decision-making;
- * Be straight forward about accidents and bad results -- never lie or coverup;
- * Document every stage of treatment;
- * Be sensitive about billing practices;
- * Avoid obvious high-risk situations, such as cases you are not fully trained or equipped to handle, patients whose personalities clash with yours, and patients who are unhappy with your treatment; and

³³ Mangels, Linda S., Ph.D., "Tips from Doctors Who've Never Been Sued," Medical Economics, February 18, 1991.

- * Treat the patient as you would like to be treated.

Even if we accept the AMA's claims about the costs and causes of "defensive medicine," curbing malpractice rights will save very little money in the health care system. According to a recent study released by the National Liability Reform Coalition, a group backed by the AMA and other medical groups, "comprehensive" restrictions on the rights of medical malpractice victims will save only between \$4 and \$9 billion per year. If you add those savings to malpractice premiums, at most, limiting the malpractice system would save between \$9 and \$14 billion per year -- or between 1.125 percent and 1.75 percent of total health care costs.³⁴

But more important, the Coalition-backed study admits that their defensive medicine numbers are based on assumptions about the causes and prevalence of defensive medicine and about physician behavior that have not been proven. The report states in the conclusion:

"...defensive medicine is a difficult concept to define. There are a variety of reasons why a physician might perform services that are not warranted, including financial incentives, patient expectations, and lack of current clinical information. The wide range of potential motives, which are also likely to overlap in many cases, make it virtually impossible to isolate the contribution of defensive medicine costs." (Emphasis added.)

In an earlier study using physician surveys, the American Medical Association estimated that "defensive medicine" cost \$20 billion in 1988. The Physician Payment Review Commission has refuted this and other figures, however, saying, "Studies that use physicians' estimates of the amount of defensive medicine they practice are not sufficiently reliable to make quantitative estimates."³⁵

³⁴"Estimating the Costs of Defensive Medicine," Lewin-VHI, Inc., January 27, 1993.

³⁵ Physician Payment Review Commission, Annual Report to Congress, 1991.

One reason it is so difficult to quantify the costs of "defensive medicine" is that there is no single definition of the term. Depending on the definition, "defensive medicine" may actually be better medicine. Measures that physicians take in response to the threat of malpractice include: telling patients more about risks, keeping better patient records, obtaining more consultations, taking better initial histories from patients, scheduling more followup visits, providing more preventive services, studying the professional literature more regularly, attending more continuing medical education courses and improving communication with their patients.³⁶ Certainly these practices could improve the quality of care and thereby reduce negligence and injury. And preventing costly injuries saves the health care system money.

Determining the causes of "defensive medicine" has proved equally elusive. We have found no empirical evidence that the liability system is responsible for a substantial amount of costly or unnecessary medical practices. Two studies from 1991 indicate that these kinds of practices are caused by a very different motivation -- the profit motive.

A 1991 study by the state of Florida found that physicians in that state own the vast majority of certain health care facilities, and that these ownership arrangements have led doctors to order unnecessary tests and questionable treatments in order to increase their profits.³⁷ The report, commissioned by the Florida Health Care Cost Containment Board, found that at least 40 percent of the practicing doctors in the state have invested in facilities to which they can refer patients. In the case of diagnostic-imaging centers, the study found that doctors own 93 percent

³⁶ Physician Payment Review Commission, Annual Report to Congress, 1991.

³⁷ Suplee, Curt, "Florida Reviews Ownership of Clinics," The Washington Post, August 9, 1991.

of such facilities. In addition, the study reported that the number of tests per patient is almost twice as great in doctor-owned labs than in those not owned by doctors. Likewise, the average per patient charge in a joint venture facility was more than twice the charge in a non-joint venture lab.

The Consumer Federation of America reported similar findings in their study of doctor ownership of diagnostic testing facilities. The report concluded, "The rapid spread of physician ownership of diagnostic testing facilities is a much more likely cause of rising diagnostic costs than defensive medicine."³⁸ The report found that physicians own or have compensation arrangements with one-third to one-half of all clinical laboratories. In the field of Magnetic Imaging Centers, physician ownership was found to exceed 50 percent. The study also reported:

- * Compared to tests ordered at independent labs, self-dealing physicians ordered 34 to 96 percent more tests;
- * Prices are 2 to 38 percent higher at physician-owned labs than at independent labs;
- * The total bill was 25 to 125 percent higher for physician-owned labs.

Before victims are forced to give up their legal rights in the name of reducing so-called "defensive medicine," the economic incentives inherent in joint venture medical facilities owned by doctors must be reduced or eliminated. Until the profit motive is removed from such medical practices, controlling the prevalence of unnecessary and expensive medical procedures will be impossible.

The Congressional Budget Office (CBO) has also found that changing medical malpractice laws is unlikely to reduce the amount of "defensive medicine." In 1992 testimony before the

³⁸ Cooper, Mark N., "Physician Self-Dealing for Diagnostic Tests in the 1980s: Defensive Medicine vs. Offensive Profits," Consumer Federation of America, October, 1991.

House Ways and Means Committee, CBO concluded³⁹:

"Moreover, if the system of medical malpractice liability were modified, the resulting change in national health expenditures would be uncertain, and, if any reductions occurred, their magnitude would probably be small. In fact, much of the care that is commonly dubbed "defensive medicine" would probably continue to be provided for reasons other than concerns about malpractice. Finally, any reductions generated by a different malpractice system might be offset by an increase in other medical services -- including high-risk ones -- either for therapeutic reasons or as a response to reductions in physicians' income."

The Office of Technology Assessment is currently conducting a study of defensive medicine that should be concluded next year. Given the dearth of other reliable information on "defensive medicine," it would be premature, at best, to pass legislation aimed at this problem before the OTA has issued its report.

CALIFORNIA'S MICRA: A FAILED EXPERIMENT

The AMA has stated that, "the most effective means of controlling medical liability costs yet devised is a set of reforms adopted in California (the Medical Injury Compensation Reform Act of 1975 - MICRA)."⁴⁰ The AMA is promoting MICRA as the model for federal restrictions on medical malpractice laws. MICRA consists of four key provisions:

(i) a \$250,000 cap on pain and suffering damages; (ii) mandatory periodic payments; (iii) allowing the jury to hear evidence of the victim's insurance coverage; and (iv) capping plaintiff's attorneys' fees. President Clinton's health care plan adopts a version of three out of the four

³⁹ CBO Testimony, Statement of Robert D. Reischauer, Director, Congressional Budget Office, before the Committee on Ways and Means, U.S. House of Representatives, March 4, 1992.

⁴⁰ "Medical Liability Talking Points," memo from the American Medical Association, June 15, 1993.

MICRA provisions -- only the cap on damages is not included.

A review of California's health care system shows that the AMA, and President Clinton, are just plain wrong -- MICRA has not reduced health care costs or increased access to health care in California. Instead, the law has provided a windfall for insurance companies, as well as physicians and hospitals guilty of malpractice, at the expense of their innocent victims.

A recent study of MICRA's effects by a citizens' group in California found⁴¹:

- * Health care costs in California rose 533 percent since the passage of MICRA, growing faster than the inflation rate in California. Since 1985, the California Medical Consumer Price Index (CPI) has grown nearly twice as fast as the inflation rate;
- * Since 1975, California's medical CPI has grown faster than the nation's, and the rate of growth in California is accelerating compared to the nation;
- * From 1986-1990, the amount insurance companies paid out in awards for medical malpractice lawsuits in California averaged only 0.53 percent of total health expenditures each year. This was only 0.14 percent lower than the payout rate for the nation as a whole. If the savings in California were applied nationally for calendar year 1991, the entire nation would have saved approximately \$1 billion in malpractice payouts -- a negligible amount compared to the \$741 billion spent on health care that year.
- * Industry profits from medical malpractice insurance in California are far higher than in the nation as a whole. Profits rose from 20 percent of premiums in 1988 to 40 percent of premiums in 1990, while the national rate rose from 8.2 percent to 29.4 percent.
- * Medical malpractice premiums paid in California are a slightly higher percentage of the state's health care bill compared to the nation as a whole, despite MICRA. Between 1976 and 1991, malpractice liability insurance premiums in California averaged 0.86 percent of the total cost of health care. Nationally, such premiums averaged 0.69 percent of the total cost of health care, 0.17 percent lower than California. Both statistics demonstrate that the price of malpractice premiums paid in California and the nation is a small fraction -- less than one percent -- of the cost of the health care system.
- * Comparisons between malpractice premiums and payouts in California and the nation show that insurers have not passed through to policyholders (i.e., doctors and hospitals) the savings that resulted from the reduction in losses since the mid-1980's. In California,

⁴¹ Rosenfiled, Harvey, "California's MICRA: Profile of a failed Experiment in Tort Law Restrictions," Voter Revolt, June, 1993.

losses dropped 38 percent between 1988 and 1990, while premiums fell only 9 percent. Nationally, losses fell 31 percent from 1988 to 1990, while premiums fell only 3 percent. (I would like to submit this study, "California's MICRA: A Failed Experiment in Tort Law Restrictions," for the record of today's hearing.)

Furthermore, according to the General Accounting Office, in 1990, California had the second highest per capita health care costs in the nation.⁴² In other words, a review of medical malpractice and health care costs under MICRA shows that, where medical malpractice insurance payouts have been reduced, insurers have not passed most of those savings to their insureds, but instead, have pocketed the difference in excessive profits. Where insurers have passed savings onto doctors and hospitals, California's high health care costs show that those savings have not been passed onto consumers in the form of lower health care costs.

As previously mentioned, California's MICRA also has not increased the number of doctors practicing in the state. In 1990, California ranked 8th in the country for number of doctors per 100,000 people, behind six states without MICRA-style laws. In 1980, California ranked 6th in the nation.⁴³

Finally, we have found no evidence that "defensive medicine" is practiced less frequently in California. In fact, an analysis of the rate of Caesarean sections performed in California indicates that the state is no different than the rest of the country. Caesarean sections are considered to be a prime example of "defensive medicine" because they are widely-acknowledged to be over-utilized and are popularly believed to reflect physicians' fears of malpractice.

⁴² "Health Care Spending; Nonpolicy Factors Account for Most State Differences," General Accounting Office, February, 1992.

⁴³ "Physician Characteristics and Distribution in the U.S.," American Medical Association, Chicago, Illinois, 1981 and 1992 editions.

Between 1985 and 1990, California averaged 23.8 Caesarean sections per hundred deliveries; the U.S. as a whole averaged 23.9 during that same time period. In 1990, California averaged 22.7 Caesareans per hundred deliveries, while the U.S. averaged 23.5 -- a difference of less than one Caesarean per hundred deliveries.⁴⁴

THE MEDICAL MALPRACTICE PROVISIONS OF PRESIDENT CLINTON'S "HEALTH SECURITY ACT"

National health care reform presents the federal government with a unique opportunity to address the epidemic of death and injury caused by negligent medical care. Thus, were pained to see that the "Health Security Act" proposed by President Clinton does almost nothing to prevent and punish medical malpractice. Instead, the bill adopts most of the key provisions of California's MICRA, and in some respects, goes even further than MICRA to restrict victims' rights.

I. Alternative Dispute Resolution Mechanisms (Section 5302)

Section 5302 requires each regional alliance plan and corporate alliance plan to adopt an alternative dispute resolution (ADR) mechanism from the alternatives developed by the National Health Board. Permissible ADR methods include arbitration, mediation, and early offers of settlement. The bill allows plan enrollees to go to court if they are dissatisfied with the determination reached in the ADR.

ADR can be a valuable and efficient tool in the resolution of civil claims, including medical malpractice claims. However, the effectiveness of any ADR system depends on its

⁴⁴ Rosenfield, Harvey, "California's MICRA: Profile of a Failed Experiment in Tort Law Restrictions," Voter Revolt, June, 1993.

ability to resolve claims in a fair, efficient and neutral fashion. Unfortunately, section 5302 fails to meet this test.

First, although the bill provides for nonbinding ADR, the mandatory nature of the provision creates an additional layer of bureaucracy for a medical malpractice victim to maneuver before he or she can get to court, increasing both cost and delay in a process that is intended to decrease time and cost. If attorneys require payment up front to cover the additional costs of the ADR, it could put litigation out of reach for moderate and low-income victims.

Second, the bill gives the health plans the job of choosing and implementing an ADR from a list developed by the National Health Board. This is unacceptable. Medical malpractice ADR procedures must not be established and administered by the health plans themselves, since the health plans will have an interest on the side of the defendants in most malpractice cases.

Third, the ADR mechanism should be court-annexed, in order to provide the usual protections of the judicial system of neutralizing the imbalances between the parties and providing an impartial judge who is guided by substantive law.

Finally, the ADR mechanism must provide for a reasonable period of discovery. Without discovery, it is virtually impossible to prove a medical malpractice case, since almost all of the relevant information is in the hands of the defendants.

II. Certificate of Merit (Section 5303)

Section 5303 requires a malpractice claimant to submit an affidavit and a written report from a medical specialist attesting that there is a "reasonable and meritorious cause" for the filing of a malpractice action.

A certificate of merit requirement is a measure that, if drafted properly, can help ensure that only meritorious malpractice claims are filed. Unfortunately, the provision in the Clinton bill is overly burdensome and too vague, leading to confusion, and in the worst case, the inability to file a meritorious claim.

First, the bill does not state whether the "qualified medical specialist" must be publicly identified, or whether the specialist will be immune from liability resulting from preparation of the written opinion. Unless the confidentiality and immunity of the reviewing expert is guaranteed, it will be extremely difficult for claimants to find experts to file written reports, even for the most meritorious claims. Most doctors would not want to go on record "accusing" other doctors so early in a case, and without protection from libel actions.

Second, the bill places an unnecessary burden on a claimant, requiring that the medical specialist's written opinion be attached to the affidavit. It is sufficient to require the claimant to file an affidavit that he or she has a written report from a qualified expert stating that the claim has merit -- it is not necessary to attach the report to the affidavit. Finally, it is overkill to demand that, in addition to the opinion of the medical expert, the unqualified claimant him or herself must attest that they believe the claim has merit.

III. Cap on Plaintiff's Attorney's Fees (Section 5304)

Section 5304 caps a malpractice plaintiff's attorney's fee at 33 1/3 percent of the award.

As representatives of consumers, we are concerned about attorneys who charge their clients unfair or exorbitant fees. In general, we believe contingency fees in personal injury cases should not exceed one-third. However, we are puzzled by the presence of this fee cap in a national health care bill. As we understand it, this legislation contains no cap on fees or salaries

for any employees in the health care industry, including doctors, drug company executives, and insurance company executives. Surely, if the goal is to decrease wasteful spending in the health care system in order to benefit consumers, health care employees' fees should also be capped, and the excess should be returned to the consumer, in the form of cash or health care benefits.

The fact that only plaintiffs' attorneys, and not defense attorneys or health care professionals, have their fees capped in this proposal, leads us to believe that the purpose of this provision is not to ensure that injured victims receive more of their damage payment, but rather, to discourage attorneys from bringing malpractice lawsuits in the first place. Fee limits may make some meritorious cases financially unfeasible due to the high costs associated with investigating and preparing some cases. Many plaintiffs with valid claims may find it difficult to obtain adequate and qualified legal representation, especially in complicated and complex cases. What is worse, those most affected by fee limits are the poor, the elderly and the young, whose cases may not be affordable with a fee cap that is set too low because they are not able to show a substantial economic loss.

At a minimum, to ensure fairness to both sides in medical malpractice claims, if plaintiffs' attorneys' fees are subject to federal price controls, defendants' attorneys' fees should also be capped. In addition, to protect victims' ability to find qualified legal representation, under no circumstances should attorneys' contingency fees be capped below 33 1/3 percent.

IV. Collateral Source Offset (Section 5305)

Section 5305 requires that a prevailing victim's damages will be reduced by the amount of "collateral source benefits" received in the past, or to be received in the future. These benefits include payments under health or disability insurance programs, employer wage continuation

programs, and "any other program" paying the victim to compensate the victim for the same injuries.

This provision is perhaps the most unfair and harmful medical malpractice restriction contained in the Clinton health care plan. First, by shifting costs onto the health insurance system, the provision is antithetical to the cost containment goals of national health care reform. Under current law, negligent doctors are responsible for paying for all the harm that their negligence has caused. Health insurers, and other "collateral source" payors, usually then have a right of subrogation, allowing them to be reimbursed by the damage payment of the doctor. This rule prevents victims from receiving double recovery, while it places responsibility where it belongs -- on the negligent provider. By forcing malpracticing doctors to pay the full costs of the injuries they cause, the collateral source rule preserves the deterrent effects of the system, and takes unwarranted costs off of the health care system.

Second, reducing damage payments by collateral benefits penalizes injured victims who have prudently invested premiums to protect themselves with insurance. The collateral source offset effectively asks consumers to invest in insurance in order to benefit negligent providers who have injured them. At a minimum, a victim's life insurance benefits and other similar benefits flowing from years of premium payments should be exempted from the offset provision.

Third, the provision calls for a reduction in damages by the amount of any future payment a victim may receive from a collateral source. However, no guidance is presented as to how to determine the amount of offset for future payments (i.e., present value of future payment, or some other method), or how to handle a situation where an anticipated future payment is deducted from an award, but is disallowed and never received. Likewise, the offset of "any other

payment" is too broad, leading to confusion and likely unfair results.

Fourth, the collateral source provision in the President's plan is even harsher than a comparable provision contained in MICRA, which only abolishes the collateral source rule of evidence, rather than requiring an automatic offset. Under California's law, the jury is allowed to hear evidence of a victim's collateral source benefits, but then it is up to the jury whether to reduce the award because of those benefits. The Clinton bill, in contrast, automatically reduces the award by the amount of collateral benefits, leaving no discretion in the jury to take into account premiums paid by the victim, or the desire to send a message of deterrence to a negligent provider.

Finally, like all the other medical malpractice provisions in this bill, the collateral source provision is entirely one-sided, favoring defendants at the expense of victims. At a minimum, if the collateral source rule is to be abrogated, evidence concerning the extent of a health care provider's insurance coverage should also be admissible into evidence.

V. Periodic Payment of Awards (Section 5306)

Section 5306 requires, at the request of any party, that all damages in a medical malpractice action to be paid periodically, based on a schedule to be determined by the court. Periodic payments at the option of the defendant are unfair and unnecessary.

First, as written, the provision could leave injured victims vulnerable and undercompensated for past, present and future expenses. During the immediate period following their injury and resolution of their claim, victims often have many debts and out-of-pocket costs that accrue. In recognition of this, most states that allow for periodic payments establish certain minimum amounts, in the range of \$150,000 to \$250,000, under which periodic payments may

not be required. Even California's MICRA sets a minimum of \$50,000 before the periodic payment requirement is initiated. Furthermore, many states allow for periodic payment of future damages only, to ensure victims can cover past and present obligations. Costs for which victims may need lump sum payments in the period closely following their injury include, immediate medical bills, purchasing expensive medical equipment, and renovating a home or moving to a new one.

Likewise, victims may need adjustments in the periodic payment schedule to allow for both unforeseen and foreseeable circumstances. For example, sometime in the future, the victim may need to have unanticipated, additional surgery, or may want to take advantage of a new medical technology. In such cases, the victim must have an ability to receive payment for these expenses, even though the cost may exceed the individual payments under the periodic payment schedule. In addition, the periodic payment schedule must take into account the effects of medical inflation, which usually exceeds the general consumer price index. As currently drafted, the court has complete discretion in designing the periodic payment scheme. To ensure full compensation to injured victims, the bill must be changed to account for inflation, and to require the court to provide for modifications in the payment schedule as the need arises.

Second, mandatory periodic payments deny victims fair compensation by effectively reducing the amount of damages deemed necessary by a jury. For example, if a defendant is permitted to pay damages over a 10 or 20 year period with no consideration for present value, then the actual amount received by the plaintiff will be substantially less than the jury intended to fairly compensate the victim. Thus, the negligent health care provider is provided a windfall at the expense of the innocent victim.

Third, the provision must explicitly state what happens if the defendant becomes insolvent or fails to make payments in a timely manner. In both instances, some mechanism must be established to ensure full and fair compensation to the victim. In addition, the compensation to the victim should not be cut off in the event that the victim dies -- it should, instead, go to the victim's estate. Any other rule would encourage insurance carriers to delay payments, in the hope that the victim will die and the payments will stop, thus rewarding defendants for the premature death of their victims.

Finally, like the other provisions in the medical malpractice title, the periodic payment requirement is unfairly tilted in favor of defendants. Although the bill requires periodic payments "at the request of any party," it is clear that this provision is designed to establish an installment schedule whenever the defendant wants it. There is no scenario I can imagine whereby an injured victim would want periodic payments but the defendant would object. Coercing victims, who have received a jury determination that they are entitled to a certain amount of compensation, into an unwanted schedule of payments is grossly unfair and completely unwarranted. It only serves to benefit the negligent provider and his or her insurance carrier, who may control, invest and earn interest on the balance of the award. Structured settlements, in which compensation payments are spread out over a number of years, can be, and often are, entered into voluntarily when they work to the advantage of both parties.

VI. Enterprise Liability Demonstration Project (Section 5311)

Section 5311 directs the Secretary of Health and Human Services (HHS) to establish an enterprise liability demonstration project under which funds will be provided to states to determine the effectiveness of holding health plans liable for the medical malpractice of their

providers, rather than holding the physicians themselves personally responsible.

Enterprise liability is a relatively new concept for us, and it is difficult to assess whether using enterprise liability in medical malpractice cases will benefit consumers until we can see an actual proposal. We do, however, have a number of questions and concerns that must be addressed in any enterprise liability scheme:

(i) By removing doctors from personal liability in medical malpractice lawsuits, enterprise liability will weaken current incentives to practice safe medicine. We understand that some people believe that enterprise liability will actually increase the oversight of medical care by health plans because of the increased liability that will be faced by the plans. We are concerned, however, that this will not be true in many instances. For example, very often, doctors who commit repeated malpractice are also big moneymakers for hospitals and health plans. We question whether health plans in such situations will deem it to be in their best financial interest to take disciplinary action against those doctors. Therefore, it is imperative that the enterprise liability scheme include a vastly improved system for oversight and discipline of doctors who practice negligent or substandard medicine.

(ii) We are also concerned that under an enterprise liability scheme, liability standards for health plans may develop differently from the rules that are now in place for physician liability. For example, whereas doctors are usually held to a high national standard of care, we fear that health plans may be held to a lower standard. The enterprise liability proposal must make clear that when a doctor is alleged to have committed malpractice, the lawsuit will proceed under traditional substantive and procedural rules for physician liability, even though the entity being sued is the health plan.

(iii) If health plans are to be liable for all the malpractice committed by their doctors, they must have adequate insurance to cover their liability. The enterprise liability plan must include a requirement that the enterprise carry a minimum amount of liability insurance.

VII. Practice Guideline Pilot Programs (Section 5312)

Section 5312 directs the Secretary of HHS to establish pilot programs at the state level to assess the effect of applying practice guidelines in the resolution of malpractice cases. To be eligible for a pilot program, a state must assure that compliance with appropriate practice guidelines will be a complete defense to a malpractice action.

This provision epitomizes the unfairness and imbalance of the Clinton malpractice proposal. Under this section, compliance with practice guidelines gives defendants an absolute defense, yet plaintiffs are not permitted to use failure to comply with the guidelines as evidence, or to create a presumption, that the defendant has been negligent. In theory, the use of practice guidelines in liability actions is meant to encourage defendants to comply with the guidelines, and to offer a measure of predictability in malpractice cases. Both of these goals will be enhanced if plaintiffs are permitted to use the guidelines affirmatively whenever defendants may use them as a defense.

In addition, this section goes too far by granting defendants an absolute defense for compliance with the guidelines. Practice guidelines may not always take account of certain specific fact situations that may arise in any given case. Therefore, it is much wiser to have compliance with guidelines create a rebuttable presumption rather than an absolute defense to liability. If the guidelines do create an absolute defense, this must be balanced by the creation of per se liability if the victim proves that the defendant did not comply with the guidelines.

In summary, each and every provision of President Clinton's proposals to address medical malpractice favor health care providers and negligent practitioners, to the detriment of injured victims, and the families of those killed by substandard medical care. To add insult to injury, the only provision in the President's draft health care bill that was released in September which sought to address the crisis of medical malpractice -- providing public access to the taxpayer-funded National Practitioner Data Bank (Data Bank) -- was deleted in the final bill. The Data Bank contains a record of federal and state disciplinary actions, hospital and professional society sanctions, and malpractice settlements and judgments taken against every doctor licensed in the U.S. It provides the best source of information about the malpractice record of physicians, but due to pressure from the medical lobby when the law establishing the Data Bank was passed, the information in the Data Bank is not available to the public or to other doctors seeking to make referrals. The Data Bank must be opened to the public so consumers can have full information about their doctors, and can protect themselves from practitioners with histories of repeated malpractice and disciplinary actions. This is especially critical in the context of the President's health care plan, which relies on competition and consumer choice to keep prices down and quality up.

CAPS ON PAIN AND SUFFERING DAMAGES

Capping pain and suffering discriminates against injured women, children, and senior citizens.

One of the most frequently cited malpractice "reforms" is placing a cap on "pain and suffering" damages of malpractice victims. While we recognize that President Clinton's health care proposal does not include a cap on pain and suffering, we feel it is important to comment

on this misguided concept because other health care bills that have been introduced do include such a provision. In the bills that we have reviewed, the cap has been set at \$250,000. This proposal would affect only the most unfortunate victims -- those who are permanently or catastrophically injured by doctor negligence -- since only the most seriously injured individuals ever receive over \$250,000 in pain and suffering awards. What is worse, studies show that even under laws that contain no limitations on damages, the most seriously injured victims are undercompensated by the legal system.⁴⁵

Furthermore, it is misguided to separate pain and suffering damages from other types of damages. Compensation for pain and suffering is compensation for real loss and should be treated in the same way as damages for out-of-pocket expenses. For example, a woman who loses her ability to ever bear children, a child whose childhood is stolen away because of prolonged illness or injury, or parents who lose their children, all suffer losses that deserve compensation, even if the loss does not result in a direct financial expense. Moreover, placing limits on pain and suffering damages has discriminatory results because it targets a very specific population -- non-wage earners. In other words, those most affected by this proposal would be women, children and the elderly. Even if this proposal would result in lower malpractice premiums, do we really want to cure the ills of the insurance system on the backs of this vulnerable population?

⁴⁵ U.S. General Accounting Office, Product Liability: Verdicts and Case Resolution in Five States, 1989.

DON'T LIMIT VICTIMS' RIGHTS, LIMIT NEGLIGENCE

Far too many innocent people are injured or killed every year due to medical malpractice. The liability system is designed to compensate the victims of medical negligence and to deter physicians from negligent behavior. The malpractice system is not perfect -- too few victims are able to recover through the courts and the incidence of malpractice continues at an unacceptably high rate. Therefore, attempts to lower the cost of health care by limiting victims rights in medical malpractice would be both misguided and cruel. The Physician Payment Review Commission concluded in its 1991 report to Congress that:

"...tort reforms tried to date are unlikely to improve significantly the malpractice system's performance...Tort reform is generally geared toward excluding claims rather than including in the system the many negligent injuries that presently do not result in claims. Neither deterrence nor defensive medicine is likely to be much affected by tort reform."⁴⁶

The only humane and effective mechanism for lowering medical malpractice costs is to limit the incidence of physician negligence and thereby lower the number of malpractice victims.

RECOMMENDATIONS

Rather than limit victims' rights, Public Citizen urges that the following reforms be implemented on the state and national levels to reduce medical malpractice and improve the quality of health care in this country:

1. Better doctor discipline is essential to reducing the incidence of medical negligence. Because a small number of doctors cause the most malpractice, removing incompetent providers from practice will lower needless injuries and deaths resulting from negligent care.

⁴⁶ Physician Payment Review Commission: Annual Report to Congress, 1991, p.382.

**** States should give licensing boards more power to discipline physicians, including emergency suspensions pending formal hearings in cases where a doctor poses a potential danger. In addition, medical board decisions should take effect while being appealed through the court system.**

**** State boards should be restructured to ensure strong consumer representation and loosen ties with medical societies.**

**** Adequate resources should be provided to the boards to ensure timely and thorough investigations of complaints. One hundred percent of license fees should go to funding the boards. In addition, Congress should create a small program of grants-in-aid to state medical boards. The grants should be tied to the boards' agreements to meet certain performance standards.**

**** Consumers must have increased access to information on physicians' medical malpractice history. The National Practitioner Data Bank that holds information about actions taken against negligent doctors should be open to the public. In addition, the Drug Enforcement Agency should release a monthly list of all practitioners whose controlled substances prescription licenses have been suspended.**

**** Insurance companies should forward all claiming and settlement information on physicians to state licensing boards.**

2. Insurance reform would ensure sensible underwriting and thereby lower costs in the health care system.

**** Insurance companies should be required to better spread risk by placing all physicians in a unified pool. Currently, the sub-categories used by insurance companies result in sky-high premiums for certain specialties.**

**** In order to differentiate "high-risk" doctors, insurance companies should charge rates based on a physician's experience. This would ensure that doctors with histories of negligent behavior would pay more.**

3. Improved physician training and oversight would limit negligent behavior, and the resulting costly injuries.

**** Risk management programs should be implemented to decrease medical negligence.**

**** Physician recertification should be implemented, requiring written examinations, and audits of medical performance through a review of patient records.**

**** Practice guidelines should be developed for certain procedures.** A 1989 Harvard Medical School study found that practice guidelines for anesthesia have drastically reduced the incidence of death or brain damage to patients. The study also found a dramatic drop in the cost of medical malpractice premiums for anesthesiologists.

**** Physicians who are aware of other doctors' incompetence should be encouraged through confidentiality and immunity to report negligence to the appropriate disciplinary body.**

4. **Voluntary alternative dispute resolution mechanisms should be established to enable medical malpractice victims with small claims to seek compensation through a streamlined system.**

Since malpractice lawsuits are almost always brought under a contingency fee arrangement, in which the damage payment must fund the attorney's fee and other costs of the suit, victims with relatively small damages -- \$50,000 and under -- are often shut out of the system because their damages cannot sustain a full blown lawsuit. Most medical malpractice lawsuits are simply too expensive to bring for the potential fee generated by a small claim. We recommend establishing a voluntary ADR process for victims with claims under \$50,000. In order to be effective, the ADR mechanism must be less expensive and more streamlined than litigation. This could be done with a lower burden of proof, abbreviated discovery, limited trial time and reducing the number of experts.

Finally, the U.S. should adopt a single-payer national health program modeled on the Canadian system. This sensible step could provide our country's residents with universal and adequate health care at the same cost as the current system, which has failed a large segment of society. A universal health program would also have the effect of reducing the numbers of malpractice lawsuits, because injured victims would not need to turn to the legal system to be compensated for their health care expenses. Those expenses would simply be paid for through the public plan.

Public Citizen will continue to work towards the goal of universal quality health care. Likewise, we are committed to working strenuously to defeat any measures that would make it even more difficult for victims of medical malpractice to recover from wrongdoers. Thank you.

APPENDIX

Table 1

Ratio of active nonfederal physicians per 100,000 civilians.

Top fifteen state for 1980 and 1990¹

Rank	State	Ratio	State	Ratio
1	District of Columbia	576	District of Columbia	658
2	Massachusetts	285	Massachusetts	364
3	Maryland*	281	Maryland*	360
4	New York	280	New York	339
5	Connecticut	264	Connecticut	332
6	California*	248	Vermont	288
7	Vermont	231	Rhode Island	277
8	Rhode Island	223	California*	272
9	Hawaii*	222	New Jersey	267
10	Colorado	210	Hawaii*	266
11	Florida*	208	Pennsylvania	256
12	Arizona	205	Florida*	251
13	New Jersey	201	Washington	241
14	Minnesota*	200	Minnesota*	240
15	Pennsylvania	197	Arizona	233

* States with AMA supported tort reform

¹ Source: Physician Characteristics and Distribution in the U.S., American Medical Association, Chicago, IL. 1981 and 1992 editions.

Mrs. COLLINS. Ms. Wittkin?

STATEMENT OF LAURA WITTKIN

Ms. WITTKIN. Few thank you. I am Laura Wittkin. I am the Executive Director of the National Center for Patients' Rights, which is a medical malpractice victims' and patients' rights advocacy and support group. I am also a victim of malpractice, and I would like to thank you for inviting me to participate here.

As I sit here today, I do feel a bit overwhelmed about the challenge of how to get everyone to understand what malpractice really means. It is not a playground for greedy lawyers and lying patients out to game the system for their own personal profits.

The reality is that medical malpractice is the sixth leading cause of death in this Nation, and while the AMA and others might not want to acknowledge it, to the average American malpractice is a devastating epidemic which we must do something about.

I would like to briefly focus on this issue from three perspectives. One is the emotional cost to victims of malpractice. The second is the disparity between the myth and the reality of malpractice, and the third is the Clinton's response to this epidemic of malpractice.

As a victim, I have been left with a lifelong disability and the constant painful reminder of what happens when regulatory systems fail to protect the public from dangerous practitioners. My case was tried in the State of California about 8 years ago, so I am painfully familiar with the MICRA law and the regressive tort reform which punishes victims and rewards wrongdoers.

As a result of that experience, I founded the Center for Patients Rights, and most of my time I will tell you is spent dealing with and handling victims who are reaching out from all over the country, desperate for help, for answers, and I think above all, accountability. And I would like to take a moment and tell you about one family that has reached out to this group.

Lucy Pappas lost her 8-year-old son, Gussie, 11 years ago from a brain aneurysm, and this is a picture of Gussie.

Gussie's aneurysm started when he was 4 years old but it was neglected, mistreated, misdiagnosed for 4 years until it finally burst. Lucy ran from doctor to doctor, and instead of getting a diagnostic work up and help, what she got were explanations such as, "Your son is just acting out for attention and you are a typical over-protective Italian mother."

When Gussie was eight his aneurysm burst and he died a painful and agonizing death and with the awareness at the young age of eight that his life was about to end.

The one doctor who did try to save Gussie's life at the end told the Pappas family he had never seen an aneurysm that large, and he was astounded that no one had picked it up for 4 years. He said that had they caught the aneurysm in time Gussie stood a 95 percent chance of full recovery and a normal life.

For Lucy and her family, Gussie's death could have happened yesterday. They are as haunted to this day about what happened to their son as they were the day he died. And the doctors responsible for their son's death are all still practicing today, many of whom have been sued again and again for malpractice.

I share Gussie's story because it typifies the human toll that malpractice takes on so many of its victims. No doctor's liability anxiety can begin to compare to the real life pain their victims are inflicted with.

Let me give you a few facts to set the record straight. As you have already heard, States that have already implemented similar tort reform as that outlined in the Clinton plan have not realized any of the so-called benefits that this administration is claiming. Ninety percent of malpractice victims don't ever bring lawsuits, so negligent doctors are already getting a free ride on the taxpayers' shoulders. We bear a \$50 billion a year price tag to provide services to victims who can't get into the system. Successful frivolous defenses by negligent doctors outweigh possible frivolous cases by plaintiffs by 12 to 1 in this country.

Insurance companies and defense attorneys routinely gain the system to siphon off profits by forcing victims to wait years for compensation. And, if this administration had really bothered to look at the issue, they would have seen that malpractice and the contention of the medical society as victims of the system is totally baseless.

Ira Magaziner said that this administration was developing tort reform based on three key principles: One, the need to increase victims access to the system. Two, the need for strong national enforcement for repeat offenders. And three, the need to reduce plaintiff and defense fees so that victims get full awards. But none of that has been realized in the Clinton plan.

Mrs. COLLINS. Your time has expired, Ms. Wittkin. Perhaps much of what you will say will come out during the questioning and answer session.

[Testimony resumes on p. 423.]

[The prepared statement of Ms. Wittkin follows:]

**TESTIMONY OF
THE NATIONAL CENTER FOR PATIENTS' RIGHTS**

Good morning, my name is Laura Wittkin. I am the Executive Director of the National Center for Patients' Rights, a medical malpractice victims' and patients' rights advocacy and support group. I am also a victim of medical malpractice. Thank you for inviting me to participate in this hearing on Medical Malpractice and Health Care Reform.

As I sit here today, I feel a bit overwhelmed by the challenge of just how to make everyone understand what medical malpractice really means. Medical malpractice is not is a playground for greedy plaintiff lawyers and lying patients out to "game" the system at everyone's expense, as the "medical establishment" would have you believe. The reality is medical malpractice is the sixth leading cause of death in this country today. That may not be a statistic that AMA wants to acknowledge, but to the average American, malpractice is a devastating national health epidemic that needs our attention immediately.

I am frustrated because victims of medical malpractice have been continually shunned and ignored by this and every other Administration. Instead of attacking the problem head-on, they have all chosen, instead, to turn a blind eye to this epidemic, turning their backs on the plight of its millions of victims. It would seem that there is national consensus that medical malpractice victims do not deserve our protection.

It is time to move beyond the baseless rhetoric of the rich and powerful interest groups and rely on the mountain of empirical studies that show a medical system in crisis -- not simply the crisis of a lack of access to health care, but the crisis of a health care system which promotes inferior and substandard care.

A system which is responsible for the deaths and injuries of nearly a half million people a year. And it is time that we address this epidemic problem and it's catastrophic fiscal impact on our nation.

Today, I would like to focus on three main points. The first, is the emotional cost to victims of this epidemic. The second, is the disparity between the myth and reality of how medical malpractice is depicted today. The third, is the overall impact of medical malpractice on the Health Care System and the Administration's response to this epidemic.

I. EMOTIONAL IMPACT OF MEDICAL MALPRACTICE:

As a victim of medical malpractice, I am left with a lifelong handicap and a constantly painful reminder of what happens when the public is left unprotected from incompetent and dangerous practitioners.

My malpractice case was tried in California, eight years ago, under the Medical Injury Compensation Reform Act, otherwise known as MICRA. Under that system I experienced firsthand the cruel and dehumanizing effects of regressive tort reform which punishes the victim and rewards the wrongdoer by callously limiting legal redress and compensation for victims. Unfortunately the Clinton Administration has adopted MICRA as its prototype, providing the foundation for their liability reform.

This experience led me to form the National Center for Patients' Rights (CPR), the largest advocacy and support group of its kind, where most of my day is spent responding to the overwhelming flood of calls and letters we receive from malpractice victims and their loved ones who are desperately crying out for help, answers, understanding, compassion, and above all, accountability. All of their stories are heartbreaking and horrifying.

I would like to give you one example of a woman who contacted CPR in 1991 desperately in search of answers:

Lucy Pappas lost her 8 year old son Gussie eleven years ago on New Year's Day from a burst aneurysm. Gussie's aneurysm, which resulted from a head injury he sustained in a car accident when he was four years old, went undiagnosed, neglected and mistreated for four years by so-called competent medical professionals who accused this child of acting out for attention and Lucy of being the typical overprotective Italian mother... until it was much too late. In fact, none of these professionals who allegedly spend so much in defensive medicine to protect themselves from liability, afforded Gussie the luxury of an adequate diagnostic workup, much less a thorough and exhaustive one.

After four years of her hopelessly failed attempts to get help for her son, Gussie's aneurysm burst. He underwent 10 hours of brain surgery to try and repair the damage. Gussie was placed on a respirator, unable to speak, his tongue wrapped in a protective cage in his mouth because he had bitten it in half from the pain he experienced during emergency surgery performed without anesthesia. Gussie died emaciated, suffering and with the terrifying awareness at the young age of eight, that his life was about to end.

Right before Gussie's aneurysm had burst, he was transferred to another facility where a pediatric neurosurgeon, who ultimately tried to save this young child's life, told the Pappas family that he had never seen an aneurysm of that size. As a specialist in this field, this doctor could not understand how Gussie had not "tried to jump off a building just to stop the pain". He was horrified that this life-threatening, yet easily detectable condition had gone undiagnosed, and told the parents that their child would have stood a 95% chance of full recovery and lived a completely normal life, had the aneurysm been caught at any time before it burst.

For Lucy and her husband, Gussie's death might as well have occurred yesterday because they are as haunted, imprisoned and consumed by the horrifyingly cruel and senseless way their child was robbed of life, as they were the day he died.

The first year after Gussie's death, Lucy spent every day at the cemetery at his crypt, from the moment the cemetery opened until it closed. Lucy could swear she heard Gussie kicking to get out. It almost drove her mad. On one desperate day when those sounds of Gussie kicking overcame her, she frantically tore at the crypt trying to pry it open with her hands. By the time she realized what she was doing her nails were torn and broken and her hands were covered in her own blood. Ultimately, Lucy realized that the kicking sound she thought she heard was, in reality, the wind passing through mausoleum.

Lucy hardly slept for the first two years after Gussie's death. At night she remained fully dressed and sat on the living room couch praying she wouldn't fall asleep, because the nightmares of Gussie's agonizing screams of pain and pleas for help had taken over her life. To this day her sleep is routinely shattered by her 8 year old son's last words, "Mommy I'm afraid to die. Please don't let me die".

All of the doctors responsible for Gussie's death are still practicing today. Some have been sued in subsequent malpractice cases by other victims. The idea that these doctors may have harmed or killed again, and that the Pappas' have been powerless to stop them, is almost more than they can bear.

I share Gussie's story with you today not because it is unusually shocking, but, tragically, because it typifies the plight and human toll medical malpractice takes on so many of its victims and their loved ones. We are tired of hearing about how much doctors suffer from the threat of malpractice litigation. We are tired of hearing how sleepless their nights are. No doctor's liability anxiety can begin to compare to the real life pain, loss and death suffered by medical malpractice victims and their families every day in this country.

II. THE MALPRACTICE MYTH VERSUS REALITY:

In view of nightmares like Gussie's, my biggest frustration with the Clinton Administration is how they depict medical malpractice victims as greedy, conniving parasites feeding off of the system, by persecuting innocent doctors for their own financial gain.

At CPR, we speak to thousands of devastated victims and families who reach out to us each year, and they simply do not fit this caricature propagated by the medical industry, which has now been embraced by this Administration.

Permit me to give you some facts to set the record straight:

- States which have adopted tort reforms similar to those outlined in the Bill, have failed to realize any of the so-called benefits this Administration claims, such as: savings to the health care system, increased access to health care, more affordable care, and reduction of "so-called" defensive medicine and "frivolous" lawsuits by plaintiffs.

The Administration, nonetheless, insists on pushing the American people down this misguided path.

- The malpractice system prevents the overwhelming majority of victims (90%) from bringing lawsuits. It is a system which already gives most negligent practitioners and providers a free ride on the backs of the American taxpayers, who must foot a staggering fifty billion dollar bill each year to provide care and services to the hundreds of thousands of victims, locked out of the legal system.
- Successful frivolous defenses by doctors, lawyers and insurance companies outnumber "possible" frivolous plaintiff's verdicts by as much as 12 to 1 in this country, according to a landmark study by the American College of Physicians, published in the Annals of Internal Medicine, October 1992. This study found that doctors currently win approximately 60% of indefensible cases at trial, compared to as few as 5% plaintiff wins in so-called defensible cases.
- Victims of malpractice are forced to wait years for redress and compensation while insurance companies and defense attorneys driven by their own financial self interests, syphon off their profits through investment earnings and uncapped defense fees for handling cases.

- Decades of failed oversight and regulation at both the state and federal level, give dangerous doctors in this country, license to kill.
- Critical performance-based information on health care practitioners is intentionally withheld from medical consumers forcing them to play Russian Roulette every time they seek medical care.
- The malpractice system is not at all biased against doctors, but is in fact, remarkably fair and lenient towards them. It is a system in which they do not lose malpractice cases they should win, and whose payouts to victims are not based on the whims of overly sympathetic jurors, but rather are consist with the extent of negligence and injury to the patient.

If this administration had bothered to look, it would have seen a system that in every way belies the medical lobbies "self-anointed" status as "victims" of the medical malpractice system.

III. THE CLINTON ADMINISTRATION'S RESPONSE TO THE MEDICAL MALPRACTICE EPIDEMIC:

Despite the overwhelming evidence about the realities of the tort system, the Clinton Administration has, nonetheless, chosen to predicate its malpractice reform proposals on false premises.

When Ira Magaziner spoke about Health Care Reform at Citizen Action's National Conference in July of this year, he said the Administration would be basing malpractice reform on three KEY principles. They wanted to design a malpractice system which would:

- 1. Increase access to the tort system for people currently locked out.**
- 2. Develop a national enforcement system for repeat malpractice offenders.**

In fact, Mr. Magaziner stated that the Administration believed that doctors who commit malpractice twice should permanently lose their right to practice medicine in this country.

- 3. Ensure that victims receive the awards that they need both in non-economic and economic damages, while limiting all attorneys fees (both plaintiff and defense).**

But the Administration delivered just the opposite of what Mr. Magaziner promised. Under the Clinton Plan:

- **Malpractice victims have even less access to the tort system than they currently do.**
- **There has been no program developed to sanction doctors who repeatedly commit malpractice, and**
- **Malpractice victims' awards will be unfairly slashed by allowing for periodic payments and elimination of the collateral source rule.**

The Clinton Administration has even reneged on its very public promise to open up the National Practitioners Data Bank to consumers.

The power of the medical and insurance lobbies is nowhere more evident than in the text of this Bill, which began with President Clinton admitting that the cost of medical malpractice accounts for less than 2% of our nation's health care bill. Yet, from this "less than two percent threat" comes legislation which virtually annihilates patients' recourse in the tort system, reduces their financial resources to deal with the harmful effects of medical malpractice...and allows malpracticing doctors to sleep better at night.

This administration's skewed expression of outrage and misdirected empathy over the emotional distress and inconvenience doctors feel when they are sued is incomprehensible. Their complete failure to acknowledge the endless, suffocating pain and devastation negligent doctors inflict victims and their families, is unconscionable.

CONCLUSION:

For us, the litmus test of whether the Clinton Administration is truly designing a health care system that is in the best interest of the American people, a system based on careful, thoughtful and honest research and analysis of the entire health delivery system, can be seen in the way they have handled the issue of medical malpractice.

We had hoped for strong leadership and progressive malpractice reform solutions which would protect the rights of innocent people harmed by medical negligence while improving the overall quality of care. Instead, what this administration has given us is simply a repackaging of the same morally bankrupt and fiscally irresponsible tort reform garbage the medical industry has been peddling for years.

The liability reform proposals outlined by the Clinton Administration are not the product of sound public policy, but rather political expediency. They will reward the wrongdoers; further punish the real victims and increase taxpayer burdens, all of which escalate the epidemic of malpractice and substantially raise health care cost spending. In short, they have FAILED to pass the litmus test.

No one will argue about the need to reform our health care system, but in the final analysis, we must all ask ourselves if we would be willing to pay for our medical care with our lives.

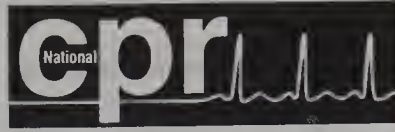
(A LIST OF RECOMMENDATIONS ARE ATTACHED)

RECOMMENDATIONS**PRO-CONSUMER FEDERAL MEDICAL MALPRACTICE LIABILITY
REFORM RECOMMENDATIONS:**

To improve the malpractice liability system and protect the rights of medical consumers and victims of malpractice, the National Center for Patients Rights recommends the following:

1. Enact a 3 year statute of limitations for the DISPOSITION of all malpractice cases (from date of filing).
2. Expedite the handling of cases involving children and terminally ill patients.
3. Create a Small Claims Arbitration Unit for all cases under \$100,000.
4. Cap plaintiff attorneys fees at 33%, with a 5% increase (to 40%) for appeals.
5. Cap Defense attorneys fees (TBD).
6. Remove all caps on non-economic damages.
7. Provide for periodic payment of awards at the request of the plaintiff only.
8. Reinstate the collateral source rule and right to subrogation in all states which have eliminated that rule.
9. Outlaw secrecy agreements.
10. Outlaw the practice of requiring plaintiffs to remove doctors names from lawsuits as a condition of settlement, to subvert reporting into the National Practitioners' Data Bank.

11. Require all physicians to carry malpractice insurance as a condition of licensure.
12. Community-rate malpractice premiums so that the costs are spread more equitably among the specialties.
13. Enact a 3 1/2 year minimum statute of limitation for filing malpractice lawsuits. That statute would be extended in cases where there has been continuous treatment, late discovery, suppression of information or criminal coverup. (This statute would not apply to minors.)
14. Require that all medical malpractice insurance carriers be audited a minimum of once every three years so that premium rates can be appropriately adjusted. Also, require that carriers submit to a full audit PRIOR to the granting of any premium increase requests.
15. Open the National Practitioners' Data Bank to the public.
16. Require all State Medical Boards to meet minimum federal standards (see attached Federal Model prepared by CPR.)



Center for Patients' Rights

666 Broadway, Suite 410, New York, N.Y. 10012
Tel. (212) 979-6670 • Fax (212) 982-3036

MODEL FOR STATE MEDICAL BOARD MINIMUM STANDARDS

In order to improve physician discipline and protect the public from harm, the Federal government should enact the following minimum requirements for all state medical boards (in alphabetical order):

1. **Board Composition:**

All Boards shall be composed of a majority of public members (at least 51%, preferably two-thirds). The Chairperson and Vice-Chair of the Board shall be public members. The size of the Board shall be based on the state's physician population (to be determined). Physician Board members shall be appointed by the Governor based solely on recommendations not nominations from a variety of recognized medical and non-medical sources (to be determined). Board members shall serve a term of no longer than 3 years (with one consecutive term).

2. **Consent Agreements:**

Boards shall prohibit plea bargains or consent agreements unless the physician agrees to plead guilty to the most serious allegation. Boards shall prohibit such agreements in negligence and incompetence-related cases unless the physician agrees to plead guilty to the most serious allegation and surrender his or her license.

3. **Consumer Protection Unit:**

Boards shall create a special Consumer Protection Unit which will consist of consumer protection officers with medical or social work background to deal directly with victim complainants. And all victim complainants shall be granted statutory immunity from liability, for libel, defamation, etc.

4. **Disciplinary Hearings:**

Board disciplinary hearings shall be open to the public, and all hearings shall adhere to a specified time frame (to be determined).

5. **Funding:**

Boards shall be allotted adequate funding in order hire the caliber of investigators, prosecutors and support staff necessary to effectively oversee the profession (and may raise physician fees to do so). All physician licensure and registration fees, and any reserves, shall be dedicated for exclusive use by the medical board. These funds may not be touched by a state for ANY reason other than the prescribed ones.

Center for Patients' Rights is a non-profit organization
dedicated to protecting the rights of medical consumers and victims of malpractice.

6. **Impaired Physicians:**
Boards shall establish an Impaired Physician Program (based on a model to be developed), and shall maintain jurisdiction over that program. Boards shall conduct an annual audit of the Impaired Physician Program and make the findings publicly available.
7. **Informal Actions:**
Boards shall share information about informal actions, such as letters of warning, with other jurisdictions.
8. **Investigators:**
Boards shall upgrade the salary and qualifications for complaint investigators (2/3's of whom shall have medical background).
9. **Licensure:**
Boards shall be responsible for both licensure and discipline of physicians. Grounds for denial of licensure shall include the following:
 - a. Any act or conduct which would constitute grounds for medical misconduct in the state in which the physician is applying.
 - b. Any disciplinary action taken in another jurisdiction, which would constitute grounds for medical misconduct in the state in which the physician is applying.
 - c. Any PENDING disciplinary investigation or action in another jurisdiction.
 - d. Loss of hospital privileges in another jurisdiction.
 - e. Malpractice lawsuits in another jurisdiction indicating that the doctor presents a risk.
10. **License Restorations:**
Boards shall require that any physician who has lost a license (as a result of surrender or revocation), wait a minimum of 5 years before applying for reinstatement of license, and must provide proof of on-going medical and remedial training (the parameters for which are to be determined).
11. **Malpractice Insurance:**
Boards shall require doctors to carry malpractice insurance as a condition of licensure. The amount of coverage shall be determined by the specialty. Physicians who perform surgery, but DO NOT have hospital privileges shall carry the same minimum coverage as physicians with hospital privileges.

12. Malpractice Data Unit:

Boards shall create a Malpractice Data Unit. This unit will be responsible for collecting all malpractice data statewide, and reviewing all malpractice claims to determine if they warrant further investigation for possible medical misconduct. This unit will also be responsible for developing a system that will flag physicians with an abnormally high number of malpractice claims or payouts. Doctors who fit these "outlier" profiles (which should be based on the size and scope of a doctor's practice, the specialty, and other risk-adjusted factors) would be subject to an automatic full-scale investigation.

13. Mandatory Reporting:

Boards shall require mandatory reporting of violations or dangerous practices by all licensees (including self-reporting by the licensee committing violation), courts, hospitals (staff and administration), all other health care providers (including HMO's clinics, etc.), liability insurance carriers, state and local medical societies and associations, state and local professional societies, other state agencies, PRO's, other health care professions, and federal agencies. All states shall impose severe civil penalties for failure to report.

Boards shall assure confidentiality to those reporting to the Board in good faith on possible violations. Board members, Board staff, individuals, and organizations required by law to report shall be granted immunity from prosecution and suit.

Liability carriers and self-insured entities must report all claims, and all payments including the dollar amount.

14. Misconduct Definitions:

Boards shall adopt uniform definitions of medical misconduct (based on a compilation of the strongest current state medical misconduct definitions).

15. Out-of-State Actions:

Boards shall not conduct a new hearing on any action taken by another jurisdiction, but shall only determine the appropriate disciplinary sanction to be imposed based on that out-of-state action. That sanction shall, at a minimum, be equivalent to the original sanction imposed.

16. Permanent Loss of License:

Boards shall permanently revoke the license of any physician convicted of medicaid/medicare fraud, fraudulent billing, child sex abuse, other sex abuse, murder (and other criminal acts, to be determined); or found guilty of falsifying or, in any way, altering medical records to conceal malpractice or other wrongdoing.

17. Physician Discipline Oversight Panel:

Boards shall establish a Discipline Oversight Panel to assess the physician discipline system. The panel shall consist of seven members appointed by the governor and may include no more than two physicians and one attorney.

(17. continued)

The panel members shall serve as individuals not as representatives of any organization, institution, agency or group. Panel members shall not participate in or review pending matters, but will review final determinations to assess the quality of work and whether the decisions are in the public interest. The panel shall assess the overall goals and objectives of physician discipline; how well the goal are being met; and whether and to what degree the process serves to minimize or deter medical misconduct. The panel may consult with medical and specialty societies, consumer organizations, other governmental organizations, state organizations, federal organizations and other states in its analysis and deliberations.

This panel shall also handle complainant appeals of cases dismissed by the Board without action.

18. Physician self-referrals:

Boards shall prohibit the practice which allows treating doctors to refer patients to clinics, labs, or other health care-related facilities or services in which that doctor, or his or her immediate family, has a financial interest. Any violation shall constitute grounds for medical misconduct. Any physician who currently self-refers shall have one year to comply with the statute.

19. Public Information and Outreach:

Boards shall have a public information officer responsible for organizing consumer and physician outreach and education programs, to include: development of a quarterly newsletter, information brochures, public serve announcements, and other outreach efforts to community groups, organizations, agencies, etc.

Boards shall set-up (and adequately staff) toll-free hotlines for consumer complaints and physician background checks. Anyone calling to check on a doctor shall automatically be entitled to the following physician "profile" information: date physician was first licensed; educational background; registration status; hospital affiliations; other states in which the doctor holds a license; the number of closed complaints against the physician (regardless of whether or not an action was taken); any formal charges pending against the physician; any disciplinary action taken against the physician's license (including a brief explanation about the basis for the action). This profile may be mailed to consumers upon request. After the federal government enacts legislation to open up the National Practitioners' Data Bank, callers will also automatically be given the Data Bank's toll-free number.

Boards shall issue an annual report made available to the public, media, legislature and other state officials. The report should contain information on licensure, including: # of applications received, licenses granted, licensure hearings, denials, temporary licenses, etc.

(19. continued)

The report shall also contain disciplinary information, including: # of complaints received (plus the source, status, category), # of actions taken, category of action; types of penalties; aggregate information about informal actions taken, etc. (Full list of items, to be developed.)

20. Recredentialing:

Boards shall require doctors to be recredentialed every 5 years as a condition of licensure. Doctors who have been involved in lawsuits or other disciplinary actions during any interim period, would be required to undergo a "clinical" performance evaluation as part of their recredentialing.

Doctors who practice exclusively in private office settings would also be required to undergo clinical performance evaluations and patient chart reviews for recredentialing.

21. Standard of Proof:

Boards shall require that the standard of proof in disciplinary actions be a preponderance of the evidence ONLY. No other standard will be acceptable.

22. Subpoena Power:

Boards shall have full subpoena power.

23. Summary Suspensions:

Boards shall have the power to issue summary suspensions which will run until a hearing can be promptly scheduled.

Mrs. COLLINS. Mr. Brennan?

STATEMENT OF TROYEN A. BRENNAN

Mr. BRENNAN. I am Troy Brennan. I teach law and public health at Harvard School of Public Health, and I am a practicing internist at the Brighams Women's Hospital.

I think that the reforms in the Health Security Act are pretty clear and they are well-documented to have effects, unlike a lot of the rest of the Health Security Act. And they will lower claims. There is good empirical evidence that suggest that these particular package of reforms will decrease claims. Not perhaps as much, perhaps, as other reforms may, but they will decrease claims.

Unfortunately, it doesn't have much vision with regard to what the medical malpractice system and the tort litigation is meant to do, which is to compensate people who have been injured by substandard care and also to deter the poor practices that led to that substandard care.

I would like to make five points based on empirical research to put the reforms in the Health Security Act in some perspective.

First of all, the first point and the most important point probably, is that there are lots of medical injuries. There is significant morbidity and mortality associated with medical injuries in American hospitals, and the first thing that we have to think about is how to improve the quality of care, especially in this particular area of the quality of care. And I am somewhat disappointed to see the Health Security Act in its quality measures does not address medical injuries.

In addition, there are great costs associated with medical injuries. Liability premiums are probably somewhere around \$10 billion a year. Defensive medicine is somewhere between \$10 and \$20 billion a year. Right now the medical care system is probably absorbing somewhere around \$60 billion a year in the costs associated with medical injuries.

The second point I want to make is that these injuries are unevenly distributed to people who are uninsured are at much higher risk for suffering medical injuries, and I applaud the Health Security Act's effort to provide access to care for all individuals.

As well, people who are hospitalized in poor hospitals are at higher risk for substandard care, and I think it is important for the administration to consider this as it begins to change reimbursement patterns.

The third point I want to make is that there is a poor match between claims and injuries. Most claims are brought in cases in which there is no injuries. On the other hand, there are few claims brought in cases in which there are injuries. The medical malpractice claiming system tends to operate as a bit of a lottery. That means that the opening up of the National Practitioner Data Bank is going to have little impact overall on the quality of medical care and will likely increase the length and cost of litigation.

It is true as well—the fourth point I would like to make is that there is inequitable claiming. The poor, the elderly and the uninsured are far less likely to bring medical malpractice claims, and none of the measures that are suggested by the Clinton administra-

tion or others today are going to do anything to address this inequity.

Finally, there is deterrence associated with the medical malpractice system. In hospitals, they have higher rates of claims where at an enterprise level we see better quality care, lower numbers of negligent medical injuries. Therefore when you begin to reduce claims you will increase the number of medical injuries due to negligence and the overall costs associated with the health care system.

I think all of these things should be taken into account as the Congress considers reform of the medical malpractice area.

Thank you very much.

Mrs. COLLINS. Thank you.

[Testimony resumes on p. 437.]

[The prepared statement of Mr. Brennan follows:]

TESTIMONY OF DR. TROYEN A. BRENNAN
ON MEDICAL MALPRACTICE AND HEALTH CARE REFORM

Introduction

Title V of President Clinton's Health Security Act directly addresses malpractice issues. Sections 5301-5312 are devoted to changes in medical malpractice that would preempt state law. In particular, the Administration recommends use of mandatory, but non-binding alternative dispute resolution mechanisms including mediation and arbitration;¹ requires plaintiffs to submit certificates of merit before initiating a suit;² limits contingency fees to 33⅓ percent;³ requires mandatory collateral source offset⁴ and the periodic payment mechanisms;⁵ and recommends experiments with exculpatory use of practice guidelines and enterprise liability.⁶

Recent reports by the Office of Technology Assessment of the Congress of the United States and the General Accounting Office suggest that these reforms will have modest impact on rates of malpractice litigation.⁷ There is no evidence to indicate that alternative dispute resolution, certificates of merit, limits on contingency fees, or periodic payment mechanisms will have any effect on the amount or intensity of malpractice litigation. On the other hand, studies do reveal that mandatory collateral source offsets will reduce the number of claims, but many

¹Health Security Act §5302.

²Health Security Act §5307.

³Health Security Act §5304.

⁴Health Security Act §5305.

⁵Health Security Act §5306.

⁶Health Security Act §5311 and §5312.

⁷See United States Congress Office of Technology Assessment, *Impact of Legal Reforms on Medical Malpractice Costs* (September 1993); United States General Accounting Office, *Report to Congressional Committees: Medical Malpractice: Alternatives to Litigation* (January 1992).

states have already adopted this reform. Contingency fees limits will likely make it more difficult for poor patients to bring suits. Mandatory arbitration practices will lengthen the process of litigation. Use of guidelines as exculpatory evidence will likely reduce the total number of claims, especially if inculpatory use of practice guidelines is prohibited as the Health Security Act envisions. Thus one can expect a modest reduction in rates of litigation, which will please providers.

But these reforms may also have detrimental effects. Tort litigation is intended to compensate individuals who have been injured and deter practices that lead to injuries. Most of the proposals by the Health Security Act will not improve the ability of the tort system to undertake these critical functions. In fact, if enacted, the Health Security Act will likely lead to less compensation for individuals injured by medical practice, will reduce deterrence of practices that cause such injuries and overall will increase the costs of the medical care system. In this testimony, I will overview recent empirical evidence that puts the Health Security Act malpractice reforms in perspective.

Medical Iatrogenic Injuries are Associated with Significant Morbidity and Mortality and Large Costs

Analyses of over 30,000 medical records in the State of New York for care rendered in 1984 indicate that of the 2.6 million people discharged from hospitals, 98,000 suffered adverse events, defined as injuries caused by medical practice as opposed to the disease process, 27,000

of which were due to negligence¹. The overwhelming majority of these adverse events led to minimal impairment or short prolongation of the hospitalization. However, 2,500 of these injuries caused permanent impairment with greater than 50 percent disability. Moreover, medical adverse events were associated with 13,000 deaths. Of these deaths, nearly 7,000 were caused by negligence, or care that failed to meet the standard expected of the reasonable medical practitioner (Table 1).

TABLE 1
POPULATION ESTIMATES OF DISABILITY CAUSED BY ADVERSE EVENTS
NEW YORK 1984+

DISABILITY CATEGORY	ADVERSE EVENTS NUMBER	NEGLIGENT ADVERSE EVENT NUMBER
Minimal impairment, recovery 1 month	56,042	12,428
Moderate impairment, recovery 1-6 months	13,521	3,302
Moderate impairment, recovery >6 months	2,762	817
Permanent impairment, 1-50% disability	3,807	869
Permanent impairment, >50% disability	2,550	877
Death	13,451	6,895
Cannot reasonably judge disability	6,477	1,989
Totals*	98,610	27,177

* Totals differ from sums of those reported above because of rounding error.

+ These are the estimates of the number of patients disabled by medical care, and the subset due to negligent medical care, at various levels of impairment for New York in 1984.

¹Brennan TA, Leape LL, Laird NM, et al. *Incidence of adverse events and negligence in hospitalized patients: results of the Harvard Medical Practice Study II.* N ENGL J MED 1991;324:377-384.

These adverse events were associated with great costs.⁹ In 1984 dollars, adverse events caused \$467 million in lost earnings and \$1.8 billion in medical care costs. If the medical care costs are adjusted to 1993 health care dollars and extrapolated from New York to the entire country, medical injuries are associated with over \$60 billion in costs, all of which the medical care system now absorbs. As we shall see, reimbursement of medical malpractice liability insurance covers very little of these costs. The figure of \$60 billion is larger than the combined estimates of the costs of medical malpractice premiums (\$10 billion) and defensive medicine (\$10-\$20 billion).

The costs of medical injuries and the total morbidity and mortality associated with adverse events and negligent adverse events underline the need for greater efforts at prevention of medical injuries. This matter of great public health importance is not clearly addressed by the Health Security Act.

The epidemiology of medical injury provides other lessons for health care reform. Medical injuries are distributed unevenly. The major individual socioeconomic risk factor for suffering a negligent medical injury is lack of insurance.¹⁰ In this regard, the Health Security Act's insistence on universal access is critically important (Table 2).

⁹Johnson WG, Brennan TA, Newhouse JP, et al. *The economic consequences of medical injuries: implications for a no-fault insurance plan.* JAMA 1992;267:2487-2492.

¹⁰Burstin HR, Lipsitz SR, Brennan TA. *Socioeconomic status and risk for substandard medical care.* JAMA 1992;268:2382-2387.

TABLE 2
MULTIVARIATE ANALYSIS OF INDIVIDUAL-LEVEL
RISK FACTORS: ADVERSE EVENTS AND NEGLIGENCE

	ADVERSE EVENTS (AE) Risk Ratio (95 % CI) +	% AES DUE TO NEGLIGENCE Risk Ratio (95 % CI) +
Male gender	0.96 (0.83-1.10)	0.84 (0.59-1.20)
Black race	1.13 (0.84-1.51)	1.48 (0.80-2.75)
PAYER STATUS		
Uninsured	0.84 (0.59-1.18)	2.35 (1.40-3.95)*
Medicaid	1.27 (0.97-1.65)	1.34 (0.70-2.55)
INCOME		
Poor	1.15 (0.90-1.46)	1.18 (0.62-2.24)
Near Poor	0.91 (0.67-1.24)	0.79 (0.34-1.84)
Low Income	0.64 (0.49-0.84)**	0.85 (0.41-1.75)
Middle Income	0.94 (0.79-1.12)	0.97 (0.50-1.90)

Calculated from multiple logistic regression, controlling for patient age and diagnosis-related risk.

*p < .001, compared to the privately insured

**p < .05, compared to higher income

+ Confidence Interval

At a hospital level, the major risk factor associated with negligent injury is the total amount of resources expended in the care of patients.¹¹ Individuals hospitalized at institutions in the lowest quartile of total operating costs are at much higher risk of suffering a negligent medical injury than are other patients. As the Administration attempts to attain control of costs,

¹¹Brennan TA, Hebert LE, Laird NM, et al. *Hospital characteristics associated with adverse events and substandard care.* JAMA 1991;265:3265-3269; Burstin HR, Lipsitz SR, Brennan. *The impact of hospital financial performance on quality of care.* JAMA 1993;270:845-849.

it must ensure that resources are distributed evenly. Otherwise patients hospitalized at relatively poor hospitals will be at much greater risk for negligent injury.

Medical Malpractice Claiming is not Matched to Medical Injuries

A review of over 68,000 medical malpractice claims in New York State uncovered 3,600 claims that arose from treatment year 1984. Since each of the 27,000 negligent adverse events theoretically could and should give rise to a medical malpractice claim, it appears that only one out of seven potential claims are actually being brought. Previous investigations have made the same point: there is a large litigation gap in medical malpractice.¹²

The more recent research combined the review of all 30,000 records with the 68,000 malpractice claims, and matched claims to individual cases. In this matching process, 51 claims were uncovered in which there was also review of the medical record, allowing estimates of the sorts of cases in which claims were being brought. Many claims (over 80 percent) are brought in cases in which there is no adverse event or no negligence.¹³ On the other hand, less than 3 percent of negligent adverse events lead to claims (Table 3).

¹²See PATRICIA DANZON, *MEDICAL MALPRACTICE*. Cambridge, MA: Harvard University Press (1985).

¹³Localio AR, Lawthers AG, Brennan TA, et al. *Relation between malpractice claims and adverse events due to negligence: results of the Harvard Medical Practice Study III*. N ENGL J MED 1991;325:245-251.

TABLE 3
ESTIMATES OF ADVERSE EVENTS, NEGLIGENT ADVERSE EVENTS AND CLAIMS
NEW YORK 1984+

	HOSPITALIZED PATIENTS	CLAIMS
No Adverse Event	2,573,253	2,267
Adverse Event	71,433	783
Negligent Adverse Event	27,177	625
Total	2,671,863	3,675

+These numbers reflect the combination of the results of the matching of claims in New York with the medical record review results. They show the estimated number of claims arising from three categories of patients: those classified as having no adverse event; those with a non-negligent adverse event; and those with a negligent adverse event.

Overall, the medical malpractice system appears quite inaccurate. Indeed it is similar to a situation in which a traffic cop is giving tickets to large numbers of motorists who are not speeding, but failing to give tickets to many speeding motorists. The Health Security Act, insofar as it emphasizes mandatory collateral source offsets and use of guidelines for exculpatory purposes, will reduce overall claiming. As a result, it is likely to reduce some of the false claims, those brought in cases in which there is no injury, but it will also reduce claims brought in cases in which there was a negligent adverse event, further reducing the already scanty compensation available to the majority of injured patients.

The medical malpractice system is also inequitable, in that certain types of patients are far less likely to bring medical malpractice claims, even when suffering significant medical injuries. For instance, uninsured patients are one tenth as likely to bring claims as patients who

have insurance.¹⁴ Poor patients are one fifth as likely to bring claims as are the wealthy. The aged are also unlikely to bring claims. Since the Health Security Act limits contingency fees, and since the poor are more dependent on contingency fee mechanisms in order to bring claims, the Health Security Act will likely worsen the inequity of the tort system. The poor will be even less likely to sue than they are at present.

The Tort System Does Appear to Deter Poor Practices

While the deterrence signal sent by the medical malpractice system must be somewhat confused, given the overall mismatch between malpractice litigation and medical injury, there is evidence that physicians are aware of and react to varying levels of medical malpractice litigation. For instance, physicians are able to gauge their risk of being sued. In fact, their perceived risk of being sued is much higher than their actual risk of being sued.¹⁵ This means that while the signal is weak, physicians are understanding it.

More importantly, recent empirical analyses demonstrate that at the level of the hospital, as claims increase per 1,000 discharges, the risk of negligent injury for patients decreases (Table 4). This is the first statistically significant evidence that there is a deterrent effect associated with malpractice litigation. It suggests that tort litigation, with all of its warts, nonetheless accomplishes the task for which it is primarily intended, that is the prevention of medical injury.

¹⁴Burstin HR, Johnson WG, Lipsitz SR, et al. *Do the poor sue more? A case-control study of malpractice claims and socioeconomic status.* JAMA 1993;270:1697-1701.

¹⁵Lawthers AG, Localio AR, Laird NM, et al. *Physicians' perceptions of the risk of being sued.* JOURNAL OF HEALTH POLITICS, POLICY AND LAW 1992;17:463-482.

TABLE 4
MULTIVARIATE HOSPITAL ANALYSIS
DETERRENCE AND NEGLIGENCE

VARIABLE*	RISK RATIO (95% CI) +
Disproportionate share status	1.4 (0.8-2.4)
Inpatient operating costs - lowest quartile	2.7 (1.5-5)*
1 Claim per thousand discharges	.94 (.68-.97)*

*Controlling for hospital location, ownership, teaching status, and length of stay.

p < .05

+ Confidence Intervals

The Health Security Act is aimed primarily at reducing medical malpractice claims. This will reduce compensation available to patients. More importantly, however, by reducing claims rates, it will reduce deterrence, and increase rates of medical injury. In addition, total costs associated with medical injury will increase.

Use of Practice Guidelines Solely for Exculpatory Purposes will Reduce Malpractice Claims

In research undertaken for the Physician Payment Review Commission, it is clear that practice guidelines are now being used in malpractice litigation.¹⁶ It appears that plaintiff attorneys are much more likely to use practice guidelines than are defense attorneys. This should not be surprising in light of the New York research. There is a large reservoir of potential claims. If practice guidelines provide an inexpensive and durable demonstration of the

¹⁶Brennan TA, Hyams AL. PRACTICE GUIDELINES AND MALPRACTICE LITIGATION: DRAFT FINAL REPORT TO THE PHYSICIAN PAYMENT REVIEW COMMISSION (October 31, 1993).

standard of care, and so make the proof of negligence easier, plaintiff attorneys are more likely to apply them than are defense attorneys.

The recent experiment with practice guidelines in Maine excludes use of practice guidelines for inculpatory purposes and allows them only for exculpatory purposes. The Health Security Act follows the same format. This one sided use of practice guidelines may seem unjust. Especially since there is huge morbidity and mortality associated with negligent injuries, it would seem advisable to use practice guidelines for both inculpatory and exculpatory purposes. Otherwise the reforms will reduce the total number of claims, particularly in the cases in which there has been a negligent injury, and hence reduce both compensation and deterrence.

Enterprise Liability

The Health Security Act recommends studies of enterprise liability. Enterprise liability exists today in many institutions. For instance, practitioners at the Brigham and Women's Hospital and the Harvard Community Health Plan in Boston, Massachusetts already practice medicine in a mature enterprise liability system. The recommendation to study practice by these physicians can easily be undertaken by the State of Massachusetts, but there is little evidence that these physicians have different attitudes towards medical malpractice than do others. Nor is there any sense that medical injury rates are higher or lower in these institutions than elsewhere.

However, if enterprise liability was linked to a system that eschewed findings of negligence and instead compensated on the basis of medical injury, one could hypothesize that there would be significant gains both in terms of prevention and compensation. The New York State research has demonstrated that a no-fault injury mechanism in medicine would be quite

affordable. For instance, the total costs of a no-fault compensation system could be accomplished for the same cost as the total amount of premiums now being paid by providers.⁹ Moreover, if medical care payments were absorbed by the health care system, as the Health Security Act envisions, no-fault insurance for the remainder of injuries is quite affordable. More importantly, all medical injuries would be compensated, not just those due to negligence.

A no-fault approach also has significant benefits from a prevention point of view. If linked to enterprise liability and experience rated premiums paid by those enterprises, one could produce significant deterrence signals at the level of the enterprise. Information on fault-based litigation suggests that deterrence is located only at the level of the enterprise; measures based on the individual physician have no effect.

A no-fault system would then provide compensation for all victims of medical injury, not just those who have suffered negligence. It would also lead to a new mind set on the part of the medical profession with regard to medical injury compensation. A similar system in Sweden is widely accepted by physicians. In fact in that country, over 90 percent of claims are initiated by physicians on behalf of injured patients. A no-fault process also accommodates notions of continuous quality improvement and epidemiological methods to reduce medical injury. American physicians are prepared to report medical injuries in a systematic effort to identify risk factors for medical injuries, and then to prevent them.¹⁷

¹⁷O'Neil AC, Petersen LA, Cook EF, et al. *Physician reporting compared with medical-record review to identify adverse medical events.* ANN INTERN MED 1993;119:370-376.

Summary and Conclusions

Many of the Health Security Act provisions are somewhat neutral with regard to an impact on medical malpractice litigation. Arbitration, periodic payment, and similar reforms will simply lengthen the duration of the litigation process. They will likely not affect claiming behavior. Changes in the contingency fee, however, will reduce the ability of the impoverished to bring suits still further. This will make the medical malpractice system even more inequitable than it is today. Collateral source offsets and use of guidelines will reduce claims, which is what many insurers and medical professional societies intend. However, these reforms will also reduce deterrence and thus increase the number of medical injuries and the costs associated with those injuries. They will also reduce compensation for individuals who have been injured. Overall, I recommend experiments with enterprise liability that incorporate no-fault concepts of compensation.

Mrs. COLLINS. Dr. Painter, I will begin with you. You cited a Harvard study which presented evidence of the extremely small percentage of injured patients who actually file claims due to the financial and other obstacles that keep most victims from being able to do so, and you also cite a Rand study which spoke to the small percentage of damages that reaches victims.

How is it that by erecting additional barriers and further limiting damages you expect to cure these problems?

Mr. PAINTER. Well, I believe those studies are simply background information on the effect that is now occurring. I think if you begin to look at existing systems where you have in place the California-type system then you can begin to see some decided improvements in reduction of costs.

For example, one of the State legislative groups that was referred to a moment ago, Indiana, where they have strong liability, studies by the Robert Wood Johnson show that more people are now compensated in that State under their law and that the average compensation is higher than in the States without such reforms. I think that is an important accomplishment.

And finally, we think that you have got to look at tort reform in the context of a total system with all of the principles that I enunciated in my testimony. Let me also indicate that it has to be coupled with a strong patient safety program which we and others in the country are outlining.

And, as you look at that, we think that the licensure boards at the State level need much more funding to allow them to do a better job, that the States ought to contract with the local society to handle complaints that are at that level. And the Maryland model is a very good one to look at to see the effectiveness of that activity in reducing and making people more conscious of the patient side of the equation.

We think expansion of drug use programs would be helpful as well as the normal risk management that every hospital and all physicians in this country participate in.

And finally, I would indicate that continuous quality improvement, which is the new coin for the quality assurance programs in institutions around the country, are looking at how they can prevent and detect and train people so that the patient events and injury would be minimized.

So we think all of this is a part of what we should deal with.

Mrs. COLLINS. Professor Brennan, let me try it with you. Dr. Painter in his written testimony stated that the Harvard study presented evidence that there was a very small percentage of injured patients that actually file these claims and that was due to financial and other obstacles that keep those victims from being able to do so, and I think you mentioned something like that also. He also stated that the Rand study spoke to the very small percentages of damages that reach the victims.

My question is, by erecting additional barriers and further limiting damages, would we in effect cure this problem?

Mr. BRENNAN. Well, it depends on how you define the problem. I think the AMA is committed to better quality care and I think they have taken a number of steps in that direction, and that is to be applauded.

On the other hand, I think it is nonetheless true that most people who suffer medical injuries do not claim. And it is also true that the reforms that are contained within the Health Security Act as well as the suggested additional reform of the cap on non-economic damages will drive down claiming so that there is less claiming by people.

So what we will see overall is that there will be less suits brought by people who have suffered medical injury due to negligence. I think that is unavoidable. And I think that will have an impact on the quality of care.

Mrs. COLLINS. Do you agree with that, Mr. Cornelius?

Mr. CORNELIUS. Yes, to a degree. I think that what we have heard here today and what you are talking about is there are a number of people out there who are hurt who don't bring suits, and this occurs for a number of reasons.

Mrs. COLLINS. Tell me why they are, what those reasons are?

Mr. CORNELIUS. OK. One of the reasons is we grew up in a society or a place where—I remember my doctor as a child, who was Dr. Dixon, and he set my bones and took care of all my medical needs. He was god. When I first told my mother who works in a hospital that I was going to sue, she told me if I did she would never speak to me again. We are brought up to believe that what these guys do are for our own good.

A lot of times people wait too long. They don't know that there is a statute of limitations of 2 years. Many times they don't know that—a doctor doesn't walk in and say, "Frank, I am sorry I messed up your leg." He sends me to another specialist and another specialist and another specialist, and pretty soon it is too late to do anything about it.

I don't see anything in this Act which will encourage people or help people to do anything. And, if you limit attorney's fees, that makes it even more difficult. It is difficult now for someone who is a victim to find an attorney who will even take the case, because at 33⅓ percent it goes on for years and years and years and years.

The doctors can afford and the insurers can afford to pay out millions of dollars in defense. I have got to ask my attorney to do it on a contingency basis of 33⅓ percent, and if he loses he gets nothing. He invests a good 3 or 4 years into this.

If we lower those any further, if we continue to put caps on top of caps, we are going to discourage people from trying to do what is right.

Mrs. COLLINS. Thank you.

Mr. McMillan?

Mr. MCMILLAN. I think part of the problem is though we are over reliant on a legalistic system. If you have an alternative dispute resolution system, it is mandatory, and it is interrelated with clinical guidelines and good medical practice, then it becomes a management tool, and maybe the remedies aren't financial but a penalty is on those who are engaged in malpractice. You don't charge them money, you take away their license, and I think that gets much more at the problem than what we are talking about.

One question that—I have always been curious about is the interest of Public Citizen in this issue, and you are an official, Ms. Gilbert, of Public Citizen and you direct Congress Watch. Does

your organization receive contributions from the American Trial Lawyers Association?

Ms. GILBERT. No, we don't. We, Public Citizen is funded by, mostly by our 160,000 members across the country. Those are individuals who pay \$20 a year to be a member.

Mr. McMILLAN. Have you analyzed your records to see how many of those are trial lawyers?

Ms. GILBERT. Well, it is very difficult, just as it is very difficult to analyze campaign contributions to see what individuals do. We have tried to do it and it is very difficult—excuse me.

Mr. McMILLAN. Do you have to make disclosure of lobbying funds?

Ms. GILBERT. Excuse me?

Mr. McMILLAN. Do you have to make public disclosure?

Ms. GILBERT. Yes.

Mr. McMILLAN. Of lobbying contributions?

Ms. GILBERT. We don't make lobbying contributions, but we do disclose all the money we spend on our lobbying efforts; yes.

Mr. McMILLAN. But the sources of those funds, though, are not disclosed; right?

Ms. GILBERT. That is right. That is right.

Mr. McMILLAN. Thank you.

Let me ask Dr. Painter a question. You didn't mention—you named a number of factors that you thought had been constructive in California, but you didn't mention alternative dispute resolution as one of those. Is that a part of the California plan?

Mr. PAINTER. No, it is not in terms of the formal law. But it is something that we support and believe is a good additional factor in the total reform package.

Mr. McMILLAN. Do you think it should be mandatory as a prerequisite and prior to litigation in a court of law?

Mr. PAINTER. Our approach is that it should be required condition as the person enters—they have to go through that before they enter a suit. We think that this is a good approach. We also believe that it needs to be tried and like many other approaches needed to see how well it works in today's world.

Mr. McMILLAN. Well, do you or Dr. Green object to the notion that practice guidelines need to be a part of alternative dispute resolution and the whole issue of malpractice reform?

Mr. PAINTER. It should be.

Mr. GREEN. I would concur that the practice guidelines should be a part of the entire ADR package. I would add that I think that probably there should be some binding decision made from ADR rather than nonbinding. My take on that would be that if it is nonbinding, then it is just going to be one side step before the next step is to go further into court.

Mr. McMILLAN. But its credibility is really important. I am certainly not proposing it as a side step. I think it would be a very constructive way in which true victims would be much more readily awarded and find much easier access to a system, but it has to work properly.

And one interrelated question with that, would you object—both of you are physicians—to that system also addressing the question of—I know this gets into State rights and State regulatory matters,

but that the system of discipline within the provider community needs to be strengthened?

In other words, damages aren't just a matter of financial reward of the victim, although that may be important, but also the penalties that are imposed upon those who engage—committed malpractice or may do so repeatedly. Should this be interrelated with that so that the issue that perhaps Ms. Wittkin was raising is addressed at the same time?

Mr. GREEN. Well, I think that having the States have more teeth in supervising the doctor in the sense that the State is watching and has control over the bad doctor, what happens I think in most instances is that the State doesn't really have the manpower, the finances or the police power to say we issued you this license, we see now that you have been called on the carpet for wrongdoing, but we can't take your license back because we don't have the manpower to cover each and every case.

Mr. McMILLAN. So the ADR system, could be incorporated in that so that where there is a finding that malpractice occurred under that system then it triggers a disciplinary action. It isn't just a question of, you know, the insurance company having to pay a claim. It goes back to the person who committed the malpractice and they are then examined as to what the cause was.

Mr. GREEN. They are held responsible. They are examined, and whether their license is allowed to continue to practice in that State should be up for discussion, up for review.

Mrs. COLLINS. The time of the gentleman—

Mr. PAINTER. I think there are two—

Mrs. COLLINS. Please continue.

Mr. PAINTER. I think there are two comments I would make. The first is the AMA feels very strongly that we must have as a part of health system reform some relief from the antitrust limitations on review of physicians and the ability to discipline those physicians. We put in place and asked our network across the country to begin start-up those disciplinary committees and review committees so they would be available to the system, and we hope that antitrust exemptions in that context would be a part of whatever reform is there.

Number two, we are particularly attracted to the Maryland model I mentioned a moment ago, where the State licensure board then can go to the local societies to ask for a peer review of the situation and get recommendations back to the individuals about the quality of care, if that is an issue, or whatever else is before them. And that way being under the State and as a part of an advisory group, the State licensure board then could accept or reject their advice vis-a-vis whether a licensure should be terminated or reduced in some way.

Mrs. COLLINS. Thank you.

Mr. Waxman?

Mr. WAXMAN. Thank you very much. I think we have to be concerned about bad doctors, and we need to be sure that the medical boards and others examine whether they ought to continue in practice.

But bad things happen to patients from doctors who are not bad doctors per se, but sometimes are negligent, just as all of us can

identify with a fact that we could have an automobile accident, and we could be negligent and the cause of that accident even though generally we are good drivers. If you don't react as quickly. You didn't take the precautions. You didn't live up to the standards.

So, I just want to point that out because I think it is important to consider.

I have listened to arguments that fear of lawsuits leads to excessively expensive medical care and causes physicians to leave the practice of medicine, and I know that to be true. I have also heard consumers argue that it is wrong and unfair to limit their common law remedies. That if they are injured they should be compensated. That is why I find the idea of enterprise liability so interesting. It would relieve individual physicians of the worry about having to defend a malpractice case, and if they didn't fear that, perhaps they would do what they think is appropriate medicine, not defensive medicine, not extra-expensive medicine, but it would still allow a patient's rights to be fully compensated in the event that there is a—not a bad result, but a bad result due to medical malpractice.

Yet, the medical profession seems very much opposed to enterprise liability, at least when it was first floated by the administration. I am interested in knowing, Dr. Green and Dr. Painter, your views on this proposal.

Mr. GREEN. I would say that enterprise liability is something that ACOG is open-minded about. That we need to see how that might work out.

I think in essence what you have here is a situation where instead of having one individual person held responsible, now you have a group, an entity held responsible. I am not sure the way our tort system works in the United States that that would change much. Instead of someone suing Dr. Green, now they may sue ABC, Incorporated. But the number of suits and the amount of dollars that are involved in the health care system might very easily remain the same.

I am not here to speak negative about it. I just think that there needs to be more data brought forth in order for me to make an intelligent judgment.

Mr. WAXMAN. Dr. Painter?

Mr. PAINTER. My response, Congressman, would be that enterprise liability as we understand it really is just a cost shift. It is not liability reform in that it is not getting to any of the causes that have caused the cost and defensive medicine and all those other issues that contribute to the rising cost due to liability.

Second, it is untested. Good theory. Sounds good, but as yet not in the real world, and certainly would need to be tested to demonstrate whether it had any particular value.

Three, it really is more of the deeper pocket situation in which you may have a collection of physicians insured by the enterprise, but again obviously having more funds available collectively, so that I think the incentive might be to sue more often rather than less often.

And finally, I think—individual physicians, I think, as a practice realize that they must be responsible for their action. Clearly, if they make a mistake or if there is injury to the patient, then that ought to be—that patient ought to be compensated.

On the other hand, as you know, the vast majority of suits are not due to events but rather more a disagreement over outcome, either expected or otherwise. And, as a consequence, I think that is where the major focus of the suits have been. So it would seem to me that transferring it over to an enterprise doesn't relieve the physician of the individual responsibility but shifts the cost indirectly, and I suspect that would come back to the physician in some way from the enterprise in which they participate.

But I think overall it ought to be tried before it ultimately might be mandated.

Mr. WAXMAN. I appreciate the answer.

And, Madam Chairwoman, I am shocked, now that I am not chairing the meeting, how fast 5 minutes go by.

Mrs. COLLINS. Mr. Greenwood?

Mr. GREENWOOD. Thank you, Madam Chairwoman, and I apologize for coming late. It has been one of those days. So I am going to ask a basic question. I would like to address it to Dr. Green.

I understand it has been one of those days for you. Is it true that you did a C-section at about 8 o'clock this morning or something like that?

Mr. GREEN. That is in fact correct. I got here a little late but still in time for the panel. I did have a delivery this morning, sir.

Mr. GREENWOOD. OK. Let me ask you a fundamental question. As an obstetrician-gynecologist practicing in the District of Columbia, can you state why it is important to have Federal medical liability reform?

Mr. GREEN. Well, we have a very difficult and complex problem here. Obviously, if we didn't we wouldn't be having these hearings. It has not been proven satisfactory that the 50 States can in fact come forth with a plan that is workable. Here in the District of Columbia where I practice there is no tort reform, and we happen to be the only jurisdiction in the United States of America that has none.

It just seems like this problem is so massive, so intricate and so detailed that it is going to require some type of Federal legislature to keep it under control, or to even make any inroads in the attempt to keeping it under control.

Individual State legislation does not seem to have worked, and I don't think it is going to.

Mr. GREENWOOD. I don't know how much you know about the political landscape in the District, but do you have any sense as to the likelihood that the elected officials in the District would undertake tort reform anytime soon?

Mr. GREEN. Well, that is a very interesting question. My feeling is that that would be highly unlikely. There have been tort reform bills entered into the Judiciary Committee of the District of Columbia governing body for about 14 or 15 years. In most instances they have never gotten out of committee to the entire Council. They die and then they resubmitted and they die again. Even as regards testimony that has been brought forth for the District of Columbia City Council, nothing still has been done.

Interestingly, although the District of Columbia City Council does not find it necessary to provide any type of tort reform for its

citizenry, the District of Columbia currently has a bill before it to put a cap on the citizenry's ability to sue the District of Columbia.

So it is interesting that what is good for the government doesn't appear to be good for the citizens, at least not here in this jurisdiction.

Mr. GREENWOOD. Do you have an opinion as to why the governing body of the District of Columbia is so disinterested, or uninterested in tort reform?

Mr. GREEN. Well, I have an opinion, yes. But I am not so sure that I should state that here. I will just say that a great many of the higher echelon administrators in our city happen to be counselors at law and there is probably some association there, I would imagine. Their campaigns are funded very heavily by the Trial Lawyers Association, and I don't think that one would be likely inclined to bite the hand that feeds it, so to speak.

Mr. GREENWOOD. I think even we can see the connection.

Mr. PAINTER. May I add one comment to your question about the importance. Let me just cite an instance in my home State of Texas along the border. We have in one of the poorest counties along the Rio Grande five practicing physicians who are now going to terminate all obstetrical services for that county just because they, one, have the problem with the premium, but number two is that they are having to spend time answering various suits, et cetera, and they simply feel that the best thing to do is curtail the service.

Mr. GREENWOOD. OK. That aims at my next question, which is how would Federal medical liability reform affect access to care in medically underserved areas? I think you have certainly responded to that, and I would like Dr. Green to do the same.

Mr. GREEN. Well, we have a tendency to think that medically underserved areas are primarily rural, and I guess for the most part they may be. But here we have a great cosmopolitan city, that being the District of Columbia, the Nation's capital, and we have an access to health care problem here.

What has happened is that the obstetricians who practice here, because of the liability climate and with no tort reform available at all, have opted to not put themselves at great risk by taking care of high-risk obstetric patients. Now these patients have great difficulty in finding a doctor who can care for them. The situation just seems to get more and more muddled, rather than clearer and clearer.

So access to care even in a metropolitan area as small as the District of Columbia is very difficult.

Mr. GREENWOOD. Thank you. Thank you, Madam Chairwoman.

Mrs. COLLINS. Thank you.

Ms. Wittkin, you wanted to say something more when you're time had expired. Do you want to talk about those other points you wanted to make now?

Ms. WITTKIN. Well, if I may, what I would like to do is just respond to a couple of things that I have heard as this discussion has unfolded, things that our organization is very well aware of and they are also contained in our recommendations.

We talk about the liability system and we talk about malpractice prevention very, very separately, and I think that is one of the key problems that we have here. Everybody looks at the liability sys-

tem without looking at what brings victims into that system, and when we talk about weak State regulatory oversight agencies and we talk about the idea of enterprise liability, what keeps coming home to me is that every oversight system that we look at, and our organization researches every system whether it is a hospital oversight system, whether it is a physician discipline system, State medical boards, peer review, all of those systems are run and dominated by this medical profession.

I think it is true to say that they are overregulated. They are looked at every single day. And yet what is amazing to me is that with all of this regulation, with all of this oversight the systems are so grossly ineffective at weeding out bad doctors and weeding out bad practices.

So when we look at State medical boards not having funding, what I think we need to do is look at the next step as to why they don't have funding, and they don't have funding because in fights that we have on State levels State medical societies have ensured that those systems remain weak.

There has to be responsibility with medical care, and there has to be a recognition that malpractice is not some sort of aberration. It happens. It happens every single day. People die every 6 minutes in this country from malpractice, and we need to have a sense of social responsibility beyond the cost of what that system is.

Mrs. COLLINS. Thank you.

Ms. Gilbert, when Mr. McMillan was questioning you, I got the impression there were some things you wanted to say.

Ms. GILBERT. Oh. I just wanted to clarify that we don't take any corporate, trade association or government funding at Public Citizen. It is all individual.

Mrs. COLLINS. Thank you.

Those two bells that you heard ringing were an indication that there is a vote on the floor of the House of Representatives. So, in the remainder of the next 3 minutes that I have I wonder if there is anything either of you would like to add on my time.

Mr. Cornelius?

Mr. CORNELIUS. I would like to add to what I said, and to be honest, I do take morphine and I don't remember everything.

When we passed legislation in 1975, we put a cap on tort reform of \$500,000. My economic losses, which we hired an economist to figure out, was \$5.5 million. I have five children. I have a wife who has told me that she wants a divorce.

What happened to me has changed my whole life. I have been in and out of the hospital 12 times. I have been administered last rites twice. And all of these are because someone was trying to help me. Someone said, you know, somebody try to be good and be held responsible. I agree with the analysis, if I drive out of here tonight, which I can't drive anymore, but if I could and I actually ran over someone I would still be responsible.

No amount of money will compensate me for the quality of life that I lead today. But \$500,000 as compared to an economic loss of \$5.5 million is unjust.

Mrs. COLLINS. Thank you.

Dr. Green?

Mr. GREEN. Madam Chairwoman, I would just like to comment that this whole topic is a very difficult, intricate and involved situation, and certainly you are going to hear comments from various factors that might suggest that there is no way we are going to make everybody happy. But the bottom line I hope that Congress takes as their message is that the objective here is to enhance the common good for the citizenry, and whatever that takes to make life better for the citizens of the United States that is what Congress should be evaluating.

Mrs. COLLINS. Thank you.

Mr. Greenwood?

Mr. GREENWOOD. Thank you. I would like to follow-up, Mr. Cornelius, on your comments about the damages. We have been talking about noneconomic damages. For instance, the bills that I cited in the earlier question all have \$250,000 caps on noneconomic damages. So no one, at least as far as this issue goes, is quarreling with economic damages. If the economic damages are \$5.5 million, these caps wouldn't affect your ability to receive that compensation, all of it.

So, my question is this. You made the comment that no amount of money can ever compensate you for what you have lost, and I certainly agree with that.

What would you do with the noneconomic damages that you receive, the extra money over the \$5.5 million? What would you do with the rest?

Mr. CORNELIUS. Two comments. One, the morphine makes me sleepy, and you woke me up earlier when you started talking about this, and I want to thank you for that.

My medical problem, reflex sympathetic dystrophy, is a problem that one of the aspects of it is constant pain, a noneconomic damage. I am in pain constantly. Prior to having the morphine pump inserted, I testified earlier, that on a scale of 1 to 10 I was in pain 24 hours a day at a 10 level. I now, with morphine being dripped into my legs and lower extremities, the pain range is around 3 or 4. I also supplement the morphine going into my body with—every 4 hours I take Tylenol 4 to help out with the pain.

So, I am not sure I am answering your question. I am not sure that \$250 or \$250 million would solve the problem. I think that our judicial system, which I have great faith in, and the jury and the judges can judge what is fair and what is not fair a lot easier than we can by sitting here today and arbitrarily saying that \$250,000 is enough for the pain and suffering.

I don't think that we have the right to do that. I don't think we have the responsibility to do it. I think that we need to leave that where it is today, or where it should be today, and that is in the judicial system.

We take in Indiana, and we have that review panel that every case must go through, and all it proved to be and all it is is a log-jam. It takes an average of 3 to 4 years for the panel to make a move. The legislation that we wrote said they were supposed to move and act within 30 days or 60 days. There is no enforcement powers. So they are not in a hurry. They are not getting compensated a great deal for leaving their practice and reviewing this

case. So it is drug out 3 or 4 years before it can ever go to court and still be litigated.

Mr. GREENWOOD. The issue is that there is a down side to not having caps, and the down side has been described as doctors giving up the practice of medicine. Areas of the country are underserved medically because of the cost of having unlimited non-economic damages. The issue for everyone is how best to ensure that all of the medical care necessary is available and paid for. All of the wage losses paid for. All of the other attendant expenses related to the injury are paid. The question is, which is more important? Is it more important to have doctors able to afford to be in the practice of medicine and all of the country being served, or for people to be able to become better off financially as a result of an injury than they were before the injury? Does that make sense?

Mr. CORNELIUS. I don't believe that anyone should enter into a malpractice lawsuit for gain, to become rich. In my case, and I can only speak to my case, I am where I am today because of negligence on the part of the doctor and negligence on the part of the hospital and on the physical therapist, and I contend that maybe the problem might be that they need to clean up their act. And, if they do and if they get rid of the bad doctors, then there will be doctors for rural areas everywhere else in the country. I don't think anyone should go without medical care. I think that they need to clean up their own act.

Mrs. COLLINS. I am sorry, but the time has expired and we have to get over there for this vote.

Let me say this. There are some questions that we still have to ask and, so I am going to ask those to whom we write the letters to please get your responses back in a very short period of time.

With that this hearing is adjourned.

[Whereupon, at 12:58 p.m., the subcommittees were adjourned, to reconvene at the call of the Chair.]

[The following statements were submitted.]

STATEMENT
of the
AMERICAN ASSOCIATION OF BLOOD BANKS
to the
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
COMMITTEE ON ENERGY AND COMMERCE
UNITED STATES HOUSE OF REPRESENTATIVES
on
MEDICAL LIABILITY REFORM

November 24, 1993

Mr. Chairman and members of the Subcommittee:

My name is Charles H. Wallas, MD. I am an Associate Professor of Pathology at Vanderbilt University Medical Center and President of the American Association of Blood Banks (AABB). On behalf of the AABB, I am pleased to have this opportunity to submit a statement regarding the unique liability concerns facing the providers of blood services and our need for medical liability reform. Please include this statement in the record of the Subcommittee's November 10, 1993 hearing on Medical Malpractice in Health Care Reform.

As the subcommittee examines proposals for reform of the Nation's health care system, the American Association of Blood Banks (AABB) urges you to enact comprehensive, nationwide medical liability reform. The AABB supports caps on noneconomic damages, periodic payment of future damages, limits on contingent attorney fees, and consideration of collateral sources when awarding damages. We also support a uniform statute of limitations for medical malpractice lawsuits and a defense for working within medical practice guidelines.

We are pleased that the Administration's Health Security Act includes many of these important reforms. However, we are concerned that as currently drafted, the medical malpractice sections of the Act may not cover actions brought against blood centers. Whatever form of medical liability reform is chosen, the AABB urges Congress to adopt legislation applicable to lawsuits involving the providers of blood services.

BLOOD SERVICES PROVIDERS ARE FACING A LIABILITY CRISIS

The American Association of Blood Banks (AABB) is the professional medical society for approximately 2,400 community, regional and Red Cross blood centers, hospital-

based blood banks and transfusion services and over 8,800 individuals engaged in blood banking and transfusion medicine. Our member facilities are responsible for collecting virtually all of the nation's blood supply and for transfusing more than 80 percent of the blood used for patient care in the United States.

The AABB is dedicated to maintaining a safe and adequate blood supply for the American people. However, in recent years our membership, which is virtually all non-profit, has been faced with expensive litigation arising from the period prior to 1985 when there was no laboratory test to screen blood for Human Immunodeficiency Virus (HIV), the virus that causes AIDS. While almost all of these lawsuits are dismissed pre-trial or won in court, the increased burden in time and other resources that this litigation has created for this component of the health care system has been staggering.

Transfusion-associated AIDS lawsuits filed through 1990 were estimated to have thus far cost the blood services community nearly \$50 million, yet blood banks were found to have been negligent in only a small fraction -- seven -- of the cases. As expected, our members' insurance situation has deteriorated. The blood banking community is currently working on the formation of a captive insurance company to bring some stability to the pricing and availability of liability coverage, but many blood establishments must now "go bare." It is essential that blood service providers be included in any medical liability reforms enacted in conjunction with overall health care reform.

MEDICAL LIABILITY REFORMS WOULD TEMPER THE COSTLY LITIGATION FOR BLOOD SERVICES PROVIDERS

Since state legislators often do not specifically address whether blood services are entitled to the protection of state enacted medical liability reforms, this issue must be litigated on a state-by-state basis. Resolution may involve complex legal arguments and result in lengthy appeals.

For example, after years of litigation, the California Supreme Court concluded that the collection, processing, and distribution of blood are professional medical services and that blood centers performing these services meet the California Medical Injury Compensation Reform Act's (MICRA) definition of health care provider. The Court decided that because blood banks provide a service that is inextricably identified with human health, they are health dispensaries entitled to the liability protections provided by MICRA.

The costs of the litigation required to obtain these rulings are enormous. We therefore urge Congress to craft Federal medical liability reform legislation so that it is clearly applicable to medical malpractice lawsuits against blood services providers.

BLOOD SERVICES ARE PERFORMED BY MEDICAL PROFESSIONALS

Including blood services in medical liability reform proposals would not only reduce litigation costs, it is good public policy. Blood services are performed by highly skilled and specialized medical professionals, including physicians, nurses, and allied health professionals. Hospitals and transfusion recipients rely on the medical skill and expertise of blood service providers in collecting, testing and processing blood.

APPROPRIATE DEFINITIONS FOR THE MEDICAL LIABILITY PROVISIONS OF THE HEALTH SECURITY ACT ARE NEEDED

We are concerned that as currently drafted, the medical malpractice reform section of the Health Security Act may not apply to the liability challenges facing the blood banking community. As president of the American Association of Blood Banks, I urge Congress to amend the definitions in the medical liability provisions of the Health Security Act so that medical liability claims against blood service providers would clearly be covered.

Section 5301(a)(1) of the Health Security Act provides that the Act's medical malpractice subtitle applies to "medical malpractice liability actions" brought in Federal or State court. A "medical malpractice liability action" is defined as a civil action brought in State or Federal Court against a "health care provider" or a "health care professional" in which the plaintiff alleges a medical malpractice claim.

Under these proposed definitions, many blood centers might inadvertently be excluded from the federal medical liability reforms proposed. This is because "health care provider" is defined as an organization or institution engaged in the delivery of health care services in a state and that is required by the laws or regulations of the state to be "licensed or certified by the State" to engage in the delivery of such services in the state.

The U.S. Food and Drug Administration (FDA) thoroughly and extensively regulates the collection, processing and distribution of blood and blood components. While some states have their own regulatory and licensing programs for blood services, many states defer to the FDA. Under the bill language, blood establishments located in states without licensure or certification programs for blood establishments would be excluded from the definition of "health care provider" and therefore, from inclusion in the medical liability reforms found in Title V, Subtitle D of the Health Security Act.

To clarify that the medical malpractice provisions of the Health Security Act are applicable to lawsuits against blood services providers, we recommend amendment of the bill's definitions so that blood services are covered. We are working on appropriate language at this time.

CONCLUSION

Amendment of the definitions in the medical malpractice subtitle of the Health Security Act is needed to insure that the subtitle is applicable to medical malpractice lawsuits against the providers of blood services.

Statement of

PHILIP H. CORBOY

CHAIR

AMERICAN BAR ASSOCIATION

Honorable Chairs and Members of the Subcommittees:

I appreciate the opportunity to present the views of the American Bar Association on medical professional liability in the context of proposals to increase access to health care. I am Philip H. Corboy, Chair of the ABA's Special Committee on Medical Professional Liability.

Since 1972, the ABA has been on record in support of legislation that would provide for every American to have access to quality health care regardless of a person's income. In February 1990, the ABA's House of Delegates reaffirmed its support of such legislation calling for universal coverage for all through a common public or public/private mechanism through which all contribute.

The American Bar Association is concerned about the ability of Americans, including its own members, to obtain affordable health insurance. Health care at a reasonable cost has been an American expectation, and a concept the American Bar Association supports. Likewise, access to the American legal system has been a fundamental right tracing back to the origins of this country.

The ABA understands the concerns being expressed about the issue of medical professional liability and is deeply committed to having a legal system in America that is effective and just, one that protects the rights of plaintiffs and defendants. Two ABA entities worked towards this end by developing recommendations for the ABA's House of Delegates. They are the Special Committee on Medical Professional Liability and the Action Commission to Improve the Tort Liability System.

The ABA Special Committee on Medical Professional Liability was composed of a balanced group of plaintiffs' lawyers, defense lawyers and representatives of academia, and the judiciary. The Committee was chaired by ABA Immediate Past-President Talbot S. D'Alemberte, then Dean of the Florida State University College of Law. The Committee was charged with studying legislative initiatives in the medical malpractice area and developing ABA policy proposals for the Association's policymakers to consider. In February 1986, the ABA House of Delegates adopted a resolution upon recommendation of the Committee. (A copy of that resolution is appended to this statement as Appendix A.) The Committee was then disbanded. However, it was reactivated in August 1991.

Near the end of 1985 the ABA, through its President, appointed an Action Commission to Improve the Tort Liability System. The 14-member Commission was asked to develop specific proposals to improve the tort liability system. The members of the Commission were federal trial and appellate court judges; a state Supreme Court justice; corporate counsel, including those with insurance experience; consumer and civil rights advocates; academicians; and practicing plaintiffs' and defense lawyers.

In February 1987, the ABA House of Delegates considered the Commission's recommendations and adopted the resolution appended to this statement as Appendix B. The ABA takes the position that these proposals to improve the tort system can and should be implemented by the courts and legislatures at the state, and not the federal level. The tort system has shown considerable resilience in the face of dramatic social and economic developments. State courts and legislatures are constantly working to improve the tort laws and should be permitted to continue to do so. Thus, federal intrusion into the field, with some exceptions, is inappropriate.

Our ABA policies reflect the ABA's recognition that the issue of medical professional liability is of vital importance not only to the legal profession but to the medical profession, the insurance industry and, most of all, to the public.

The public has the most at stake in this issue. When a person suffers injury as a result of negligence by a provider of health care services, he or she must have the right to seek recovery for the full measure of those damages. We believe that right is severely threatened by those who call for major changes in this country's tort law system, and particularly by those who propose that limits be placed on the amount of damages persons may seek in compensation for their injuries caused by the negligence, or carelessness of health care providers.

We are especially concerned with proposals to alter the system of medical malpractice to carve out exceptions in the tort law system for one group of potential defendants -- in this case, the medical profession. It is the ABA's belief that the rights of injured persons to recover fully for injuries caused by the wrongful acts of others must be protected. We are concerned that those who seek major changes in the way the tort law system deals with cases of medical malpractice are willing to trade away the rights of all individuals in the hope of easing a perceived burden on some or reducing the overall costs of health care. Since medical malpractice insurance costs make up only a small fraction of the dollars spent on health care in the United States, the changes in the tort laws would have no real impact on costs of health care.

In addressing access to health care proposals, that contain provisions on medical professional liability, three questions need to be asked. First, what is the cost savings that can be achieved? Second, have such provisions, when enacted, lowered health care costs in states which have adopted their essential elements? Third, what are the consequences to the traditional American legal system and to the rights of the injured persons? In other words, does a cost shifting from the medical professional who caused the injuries to the person who was injured or to a governmental agency achieve anything more than an illusory savings?

WHAT IS THE COST OF THE MEDICAL-LEGAL SYSTEM?

The American Bar Association does not purport to possess the expertise to analyze all of the reasons for escalating medical costs. We do, however, have the ability to analyze the interrelationship of the legal system and those costs. Moreover, we are able to determine the consequences of proposed legislation upon the American legal system and those seeking compensation for injuries.

The major components that have been cited as contributing to the rising cost of that care are:

- * Reliance on modern, sophisticated and expensive treatment.
- * Innovative treatment of illnesses, such as heart disease, AIDS and cancer;
- * An aging population, which adds to Medicare and Medicaid expenditures;
- * High administrative costs of the health care system; and
- * The medical-legal system.

Studies concerning the medical-legal system show that its impact on the national expenditures is not only questionable but also insignificant.¹ The Congressional Budget Office stated in 1992 that medical-legal costs, as measured by medical malpractice insurance premiums, account for 0.74 percent of the national health expenditures.² I understand that these insurance premiums account for a lower percentage of national health expenditures at this point in time. The other component of cost attributed to the legal system is that of so-called "defensive medicine." Varying figures for the cost of "defensive medicine" have been estimated. However, no one has reliably measured what, if anything, defensive medicine costs.

An October 1992 study of the Congressional Budget Office concluded that health care spending is propelled upward by high-cost technological and medical breakthroughs. The study finds that rising incomes, demographic changes, and medical malpractice costs do not appear to account for much of the increase in the nation's health care bill. The report states that malpractice insurance premiums account for less than one percent of the dollars spent annually on the nation's health care.

The report also concluded that "much of the care that is commonly dubbed 'defensive medicine' would probably still be provided for reasons other than concerns about medical malpractice. Physicians have always sought to provide patients with the best possible medical care at the lowest risks and would continue to do so even without the threat of lawsuits. Because much of this 'defensive care' helps to reduce the uncertainty of medical diagnosis, it seems unlikely that physicians would change their practice patterns dramatically in response to malpractice reform."

To address the subject of "defensive medicine," there must be agreement upon the meaning of the phrase. However, there is no agreement upon the definition.⁴ That uncertainty has resulted in the inability to statistically measure the cost.⁵ In published studies, "defensive medicine" has included erroneously the cost of the consequence of physicians' financial incentive to direct patients for tests and examinations in facilities in which physicians have a proprietary interest.⁶ Some have considered the cost of new technology and advancements in medical knowledge, care and treatment. In that regard, patients expect the use of very modern, sophisticated and expensive technology to refine diagnosis and eliminate uncertainties.

Therefore, to examine the impact of the medical-legal system, the necessary inquiry is to what extent physicians direct medical expenses that are unwarranted for the treatment or diagnosis of patients, and are not motivated by personal financial interests. In other words, an expense is only attributable to the medical-legal system when the sole reason for that expense is concern by the physician about a medical malpractice claim. There has been no study to measure that cost, and there appears to be no basis for assuming that competent and reputable physicians impose such expenses upon their patients without a justifiable medical reason.

To the extent that physicians' concern about liability results in more conscientious medical care, then "defensive medicine" is certainly desirable.⁷ When the fear of tort liability deters medical injuries, then health care costs are lowered by avoiding the costs associated with medical injury.⁸ Thus, if liability concerns are a deterrent, provisions that

relieve physicians of concern regarding negligent practices can actually result in an increase of health care costs.

Because no reliable studies have been done to estimate the cost of so-called defensive medicine, the Office of Technology Assessment has been asked to study the issue and is expected to complete its study in 1994.

**HAVE TORT PROPOSALS, WHEN
ENACTED, LOWERED OVERALL HEALTH CARE COSTS?**

It is often asserted that caps on noneconomic damages and elimination of the collateral source rule result in lower health care costs for everyone. In general, these types of proposals have been enacted only within the last ten years. Insufficient time has elapsed, and insufficient data has been gathered to enable us to be certain of the impact on costs of these proposals. However, from our research and study it appears that these proposals have not had any measurable impact on overall health costs. In looking into the issue we found that personal health care spending per capita approximately doubled throughout the United States from 1982 to 1990 regardless of whether a state had enacted "tort reforms" and regardless of the type of "reforms" enacted. We developed a chart (attached as Appendix C) showing the percentage of increase from 1982 to 1990 in personal health care spending per capita by state. It is derived from a February 1992 report entitled "Health Care Spending - Nonpolicy Factors Account for Most State Differences," published by the General Accounting Office (GAO). The GAO report utilized 1982 data compiled by the Health Care Financing Administration (HCFA) and 1990 estimates from Lewin/ICF.

As the chart demonstrates, personal health care costs approximately doubled from 1982 to 1990 regardless of whether a state had enacted tort "reforms" and regardless of the type of "reforms" enacted.

For example, based on the figures utilized in the GAO report, the three states with percentage increases estimated to be slightly lower than average -- Arkansas, Kentucky and Mississippi -- had no caps on damages in medical malpractice cases. Alabama, with a slightly higher than average estimated percentage increase, had a cap on damages. Massachusetts and California, the two states with the highest estimated personal health care costs per capita, had in place a cap on damages.

Our findings are consistent with other studies. For example, in March 1993, the Coalition for Consumer Rights published False Claims: The Relationship Between Medical Malpractice "Reforms" and Health Care Costs. This study found there to be "no indication that enacting major tort 'reforms' is

positively correlated with lower health care costs." In fact, the study found that "states with the lowest per capita expenditures are more likely to have enacted fewer tort 'reforms' overall than the average." Regarding caps on damages, the Coalition's study concluded as follows:

Since the medical establishment has made caps on damages its single highest priority, we would expect to see some correlation between states which have limits on recovery and inexpensive health care. However, only 30% of the ten states spending the least in health care have enacted limits on recovery of damages; 55% of the remaining 40 states have such a statute. A closer examination of the states ranked by spending shows that there is no correlation between the least expensive states and limits on damages.

Our findings are consistent with previous research we have conducted on the "health care savings" of caps. Indiana has one of the most restrictive caps laws in the nation, and yet a 1992 survey of hospital bed costs and delivery charges in comparable cities in Illinois and Indiana revealed that the small variance in fees could not be attributed to lower medical malpractice costs coming from caps on awards.

A recent study funded by the Texas Medical Association, the Texas Trial Lawyers Association and the Texas Hospital Association reported that its findings indicated that "changing the medical professional liability system will have minimal cost savings¹⁰ impact on the overall health care delivery system in Texas.

The cost of medical malpractice insurance, for the most part, reflects the cost of the medical-legal system. In contrast to the increase in health care costs, medical malpractice costs have been stable in recent years.¹¹ The number of medical malpractice claims peaked in 1985, and has continued to decline according to the most current figures available. From 1985 to 1990, the overall rate declined at an average annual rate of 8.9 per cent.¹²

**WHAT ARE THE CONSEQUENCES TO THE PUBLIC OF
PROPOSALS TO CAP NONECONOMIC DAMAGES OR ELIMINATE
THE COLLATERAL SOURCE RULE IN MEDICAL MALPRACTICE CASES?**

Proposals of this type are ill-advised. Elimination of the collateral source rule solely favors medical professionals by passing on the cost of the medical injury to another health care

provider. Often, an insured person has the benefit of health or disability insurance which pays for a portion of the additional medical costs attributable to the injuries caused by a physician's negligence. Typically, the insurer will assert a lien against its insured's recovery or pursue a subrogation claim. Under proposals to eliminate the collateral source rule, the negligent physician would get a credit for the insurer's payment, and the insurer could not recover from the person who injured its insured. An obvious consequence of the loss of lien and subrogation rights by a health or disability insurer will be an increase in those premiums. Where government proposals provide such insurance, government health care costs would increase. The net result is no reduction in health care costs but a windfall benefit to the defendant medical professional and his or her insurer at the expense of the injured person.

Proposals to limit noneconomic damages deprive individuals of compensation for the consequences of medical malpractice injuries. No one has stated that such injuries are not real or severe. In fact, noneconomic injuries may far exceed the economic damages. These proposals, if enacted, would make seriously injured persons who are the least able to afford it receive less than full compensation while less seriously injured persons would be fully compensated. This would be grossly unjust.

A bottom line is whether the economic benefits to the public in reducing health care cost is significant enough to warrant depriving other members of the public -- injured persons -- of full and adequate compensation from those responsible for their injuries. With the cost of the entire medical-legal system constituting less than one percent of health care costs, a pertinent inquiry is whether such proposals would have any noticeable impact except upon injured persons.

Such proposals would not eliminate the less than one percent of health care costs attributable to medical professional liability since no one seriously urges that the medical profession should be immune from liability. Rather, such proposals are directed at those injured persons who are ultimately compensated. These victims of medical negligence are the subject of such proposals. Any savings in the cost of health care would be a small fraction of a percent. Thus, even on an economic analysis, such proposals, if implemented, will not have a measurable impact upon the cost of health care. Such proposals, however, would impact severely and dramatically upon the persons who are victims of medical malpractice.

**SHOULD ALTERNATIVE DISPUTE RESOLUTION
BE INCLUDED IN A NATIONAL HEALTH ACCESS PROPOSAL?**

The ABA has long supported the use of various methods of alternative dispute resolution (ADR) and was an early leader in advocating for its use. We encourage providing appropriate ADR options in a national health access proposal as an efficient means of expediting medical malpractice claims.

In 1976, the ABA co-sponsored a conference in St. Paul, Minnesota. The conference sought to address two principal topics: "What types of disputes are best resolved by judicial action and what kinds are better assigned to another more appropriate forum?," and "Can the interest of justice be better served with processes less time-consuming and less expensive?" The conference discussions led to the appointment of a "Pound Conference Follow-up Task Force," under the chairmanship of Judge Griffin Bell. The Task Force published a report with numerous recommendations for justice reform in August, 1976.

A principal recommendation of the report is that a variety of innovative dispute resolution techniques be explored: arbitration, mediation, revitalized and expanded small claims courts, and the concept of a "neighborhood justice center."

In 1977, when the ABA established its Standing Committee on Dispute Resolution, that subject was relatively obscure; however, during the past 16 years, the ABA through its Standing Committee and its newly established Section on Dispute Resolution, has chartered the nation's dispute resolution agenda. The Multi-Door Courthouse, school mediation and police dispute resolution programs were unknown concepts until after the ABA's 1976 Conference on Improvements in the Administration of Justice.

Today, the dispute resolution world is dramatically different. Much has happened, in part because of ABA leadership. The extensive work of the ABA is described in a document entitled the ABA Blueprint for Improving the Civil Justice System. Copies of the "Blueprint" are available upon request.

The ABA's House of Delegates has adopted four resolutions relevant to ADR and medical malpractice. The resolutions call for the following:

1. To promote continued use of and experimentation with ADR, both before and after suit is filed, as welcome components of the justice system.
(Adopted August 1989.)

2. Consistent with the attached ABA policy (Appendix D), to support the increased use of ADR by federal agencies, which included support for the recently passed Administrative Dispute Resolution Act of 1990. (Adopted August 1988.)
3. To support the use of arbitration for resolution of medical malpractice disputes under circumstances whereby the agreement to arbitrate is entered into only after a dispute has arisen. (Adopted August 1977.)
4. To support the voluntary use of arbitration so long as the parties have full knowledge that once entered into, the arbitration panel's decision is final and binding; and that arbitration panels should consist of one impartial arbitrator in "small" claims cases and three arbitrators - an attorney, a physician, and a layman in larger claims cases. (Adopted August 1976.)

The ABA is concerned about achieving a more expeditious and economical resolution of medical malpractice litigation. Voluntary alternative dispute resolution, for example, has gained acceptance as an alternative to litigation. The ABA recognizes the importance of the development and use of ADR methods other than full judicial trials for resolving legal disputes. ABA policy supports the "continued use of and experimentation with alternative dispute resolution techniques both before and after suit is filed," so long as they assure that every disputant's constitutional and other legal rights and remedies are protected. Of course, such concepts have equal validity in litigation against any defendant, and no special justification exists for being applied only in cases involving medical professionals.

The use of voluntary alternative dispute resolution techniques is consistent with the relevant policy considerations of attracting to an overburdened judicial system the independent and impartial services and expertise upon which that system necessarily depends. Besides relieving court congestion and speeding up the conclusion of cases, these alternative dispute resolution procedures are often less expensive and less stressful than seeing a case through its normal trial path.

Thank you for giving us this opportunity to present our views to you.

ENDNOTES

- 1 According to the 1992 U.S. Industrial Outlook prepared by the U.S. Department of Commerce, in 1991 national health care outlays accounted for approximately 13 percent of the GNP, totaling \$738 billion up about 11 percent from \$666 billion in 1990. The medical-legal component in the same period, however, appears to have decreased since health care costs greatly increased during this period and malpractice premiums have been stable during the past several years.
- 2 Testimony, Robert D. Reischauer, Director, Congressional Budget Office, Statement before the Committee on Ways and Means, U.S. House of Representatives, March 4, 1992.
- 3 Congressional Budget Office, Economic Implications of Rising Health Care Costs (October 1992) page 27.
- 4 The American Medical Association has estimated the cost of defensive medicine based upon a survey of physicians who were asked, for example, whether they ordered more tests because of the perceived risk of a medical malpractice claim. The AMA, moreover, recognized other reasons contributed to an affirmative response, stating, "like other defensive measures, all defensive medicine cannot be characterized necessarily as overuse but can reflect necessary improvements in patient care." Statement on behalf of the American Medical Association to the Senate Finance Subcommittee on Medicare and Long Term Care Regarding Medical Liability Reform, October 16, 1991, page 4.
- 5 The Physician Payment Review Commission (PPRC) has questioned such figures, noting that "Studies that use physicians' estimates of the amount of defensive medicine they practice are not sufficiently reliable to make quantitative estimates." Physician Payment Review Commission 1991 Annual Report to Congress, page 374.
- 6 Mark N. Cooper, "Physician Self-Dealing for Diagnostic Tests in the 1980s: Defensive Medicine vs. Offensive Profits," Consumer Federation of America, October 3, 1991, reported that the rapid spread of physician ownership of diagnostic testing facilities is a much more likely cause of rising diagnostic costs than fear of malpractice liability.

A January 1991 study by the State of Florida's Health Care Cost Containment Board looked into physician ownership of health care facilities. It found that joint ventures among health care providers resulted in higher health care costs due primarily to the over-utilization of services.

A study of radiation centers in Florida found that doctor-owned centers appeared to result in a substantial increase in use and cost of the services. See Mitchell, Jean M.; Sunshine, Jonathan H.; "Consequences of Physicians' Ownership of Health Care Facilities - Joint Ventures in Radiation Therapy, The New England Journal of Medicine, Vol.327, No.21, Nov. 19, 1992, pages 1497-1501.

Another study examined workers' compensation claims in California and found that self-referral increases the cost of medical care covered by workers' compensation for physical therapy, psychiatric evaluation services and MRI Scans. Swedlow, Alex; Johnson, Gregory; Smithline, Neil; and Milstein, Arnold, "Increased Costs and Rates of Use in the California Workers' Compensation System as a Result of Self-Referral by Physicians," The New England Journal of Medicine, Vol.327, No.21 Nov. 19, 1992, pages 1502-1506.

- 7 Patricia M. Danzon, "Liability for Medical Malpractice," Journal of Economic Perspectives, Vol.5, No.3, Summer 1991, pages 51-69. Ms. Danzon concludes that liability concerns have brought about some efficient changes in practice.

The Physician Payment Review Commission Annual 1991 Report also discusses other possible causes of inefficient and inappropriate defensive medicine.

- * Physicians and hospitals often benefit financially by delivering more care.
- * Insurance does not deter physicians from ordering additional tests because insurance provides funding for that which a patient could not otherwise afford.
- * So-called defensive medicine practices often have become the standard of care adopted by the medical community, and reflect an advancement in technology or care.

- 8 Testimony, Robert D. Reischauer, Director, Congressional Budget Office, Statement before the Committee on Ways and Means, U.S. House of Representatives, March 4, 1992, Appendix F, page 32.

- 9 Andrea Dubin, False Claims: The Relationship Between Medical Malpractice "Reforms" and Health Care Costs, prepared for the Coalition for Consumer Rights, March 1993, at Page 2.

- 10 "Medical and Hospital Professional Liability," a report prepared for the Texas Health Policy Task Force by Tomm and Associates, July 1992.

- 11 1989 Profitability Study (By Line By State), 1990 Profitability Study (By Line By State), and 1991 Profitability Study (By Line By State), National Association of Insurance Commissioners, 1990, 1991 and 1992.

- 12 Martin L. Gonzalez "Medical Professional Claims and Premiums 1985-1990," Socioeconomic Characteristics of Medical Practice 1992, page 23.

APPENDIX A.

E. No disclosure of financial worth by a defendant in a tort action should be required unless there is evidence showing by evidence in the record or proffered by the plaintiff that would provide a legal basis for recovery of punitive damages.

F. Notices of intent to sue, screening panels and affidavits of non-involvement are unnecessary in medical malpractice actions.

G. No justification exists for a special rule governing punitive prosecution actions brought by health care providers against persons who sued them for malpractice.

H. Trial courts should scrutinize carefully the qualifications of persons presented as experts to ensure that only those persons are permitted to testify who, by knowledge, skill, experience, training or education, qualify as experts.

I. The collateral source rule should be retained; and third parties who have furnished monetary benefits to plaintiffs should be permitted to seek reimbursement out of the recovery.

J. Contingent fees provide access to the courts; and no justification exists for imposing special restrictions on contingent fees in medical malpractice actions.

K. The use of structured settlements should be encouraged.

L. Collection and study of data on the cost and causes of professional liability claims should be undertaken to evaluate and develop effective loss prevention programs.

RESOLUTION APPROVED BY THE
AMERICAN BAR ASSOCIATION
HOUSE OF DELEGATES

FEBRUARY 11, 1986

BE IT RESOLVED,

1. The American Bar Association urges appropriate AMA entities, such as the Action Commission to Improve the Tort Liability System and the Committee on Professionalism, to continue to consult, where appropriate, with representatives of the American Medical Association and others in the health care industry, the insurance industry, state and federal governments and appropriate segments of the public with the goal of seeking a broader consensus on how more equitably to compensate persons injured in our society. The problems associated with medical professional liability are common to all areas of tort law and should be evaluated in the context of their broader implications for the tort system as a whole. The legal and medical professions should cooperate in seeking common solutions to these problems and should avoid any efforts to polarize the discussion of these problems, which would serve neither the public interest nor the interests of either profession.

2. Consistent with these goals, the American Bar Association adopts the following principles:

A. The regulation of medical professional liability is a matter for state consideration; and federal involvement in that area is inappropriate.

B. There should be rigorous enforcement of professional disciplinary code provisions which prescribe lawyers from filing frivolous suits and defenses; and sanctions should be imposed when those provisions are violated.

C. There should be more effective procedures and increased funding to strengthen medical licensing and disciplinary boards at the state level; and efforts should be increased to establish effective risk management programs in the delivery of health care services.

D. No justification exists for exempting medical malpractice actions from the rules of punitive damages applied in tort litigation to deter gross misconduct.

RESOLUTION APPROVED BY THE
AMERICAN BAR ASSOCIATION
HOUSE OF DELEGATES

February 16-17, 1987
(Report No. 123)

Be it resolved, That the American Bar Association adopts
the following recommendations:

A. Insurance

1. The American Bar Association should establish a
commission to study and recommend ways to improve the liability
insurance system as it affects the tort system.

B. Pain and Suffering Damages

2. There should be no ceilings on pain and suffering
damages, but instead trial and appellate courts should make
greater use of the power of remittitur or additur with
reference to verdicts which are either so excessive or
inadequate as to be clearly disproportionate to community
expectations by setting aside such verdicts unless the affected
parties agree to the modification.

3. One or more tort award commissions should be
established, which would be empowered to review tort awards
during the preceding year, publish information on trends, and
suggest guidelines for future trial court reference.

4. Options should be explored by appropriate AAA
entities whether additional guidance can and should be given to
the jury on the scope of damages to be awarded for pain and
suffering in a particular case.

C. Punitive Damages

5. Punitive damages have a place in appropriate
cases and therefore should not be abolished. However, the
scope of punitive damages should be narrowed through the
following measures:

a. Standards of Conduct and Proof

Punitive damages should be limited to cases
warranting special sanctions and should not be commonplace. A
threshold requirement for the submission of a punitive damages
case to the finder of fact should be that the defendant
demonstrated a conscious or deliberate disregard with respect
to the plaintiff. As a further safeguard, the standard of
proof to be applied should be "clear and convincing" evidence
as opposed to any lesser standard such as "by a preponderance
of the evidence."

b. The Process of Decision

(1) Pre-Trial - Appropriate pre-trial procedures
should be routinely utilized to eliminate frivolous claims for
punitive damages prior to trial, with a savings mechanism
available for late discovery of misconduct meeting the standard
of liability.

(2) Trial - Evidence of net worth and other
evidence relevant only to the question of punitive damages
ordinarily should be introduced only after the defendant's
liability for compensatory damages and the amount of those
damages have been determined.

(3) Post-Trial - As a check against excessive
punitive damage awards, appellate courts including such awards should
be subjected to more scrutiny by the courts. The trial court
should order remittitur whenever justified. Excessive awards
should be evaluated in light of the degree of reprehensibility
of the defendant's acts, the risk undertaken by the plaintiff,
the actual injury caused, the net worth of the defendant,
whether the defendant has reformed its conduct and the degree
of departure from typical ratios (as reflected in the best
available empirical data) between compensatory and punitive
damages. If necessary to assure such judicial review,
appropriate legislation should be enacted. Opinions issued by
trial or appellate courts either upholding or modifying an
award should specify the factors which were considered and
relied upon.

c. Multiple Judgment Torts

While the total amount of any punitive damages
awarded should be adequate to accomplish the purposes of
punitive damages, appropriate safeguards should be put in force
to prevent any defendant from being subjected to punitive
damages that are excessive in the aggregate for the same
wrongful act.

d. Vicarious Liability

With respect to vicarious liability for punitive
damages, the provisions of Section 909 of the Restatement
(Second) of Torts (1979) should apply. Legislatures and courts
should be sensitive to adopting appropriate safeguards to
protect the employer or principal from vicarious liability for
the unauthorized acts of nonmanagerial servants or agents.

e. To Whom Awards Should Be Paid

In certain punitive damages cases, such as torts
involving possible multiple judgments against the same
defendant, a court could be authorized to determine what is a
reasonable portion of the punitive damages award to compensate
the plaintiff and counsel for bringing the action and
prosecuting the punitive damage claim, with the balance of the

F. Secrecy and Coercive Agreements

10. Where information obtained under secrecy agreements (a) indicates risk of reprisals to other persons, or (b) reveals evidence relevant to claims based on such reprisals, courts should ordinarily permit disclosure of such information, after hearing, to other plaintiffs or to government agencies who agree to be bound by appropriate agreements or court orders to protect the confidentiality of trade secrets and court orders proprietary information.

11. No protective order should contain any provision that requires an attorney for a plaintiff in a tort action to destroy information or records furnished pursuant to such order, including the attorney's notes and other work product, unless the attorney for a plaintiff agrees to agree to be bound by the order after the case has been concluded. An attorney for plaintiff should only be required to return copies of documents obtained from the defendant on condition that defendant agrees not to destroy any such documents so that they will be available, under appropriate circumstances, to government agencies or to other litigants in future cases.

12. Any provision in a settlement or other agreement that prohibits an attorney from representing any other claimant in a similar action against the defendant should be void and of no effect. An attorney should not be permitted to sign such an agreement or request another attorney to do so.

G. Streamlining the Litigation Process: Frivolous Claims and Unnecessary Delay

13. A "fast track" system should be adopted for the trial of tort cases. In recommending such a system, we endorse a policy of active judicial management of the pre-trial phases of tort litigation. We anticipate a system that sets up a rigorous pre-trial schedule with a series of deadlines intended to ensure that tort cases are ready to be placed on the trial calendar within a specified time after filing and trial promptly thereafter. The courts should enforce a firm policy against continuances.

14. Steps should be taken by the courts of the various states to adopt procedures for the control and limitation of the scope and duration of discovery in tort cases. The courts should consider, among other initiatives:

(a) An early scheduling conference, limiting the number of interrogatories any party may serve, and establishing the number and time of depositions according to a firm schedule. Additional discovery could be allowed upon a showing of good cause.

(b) When appropriate, sanctioning attorneys and other persons for abuse of discovery procedures.

ward to be allocated to public purposes, which could involve methods of dealing with multiple tort claims such as consolidation of claims or forms of class actions. The novelty of such proposals and the absence of any adequately tested programs for implementing them require further study before an informed judgment can be made as to whether, or to what extent, such proposals will work in practice. We urge such studies. The concept of public allocation of portions of punitive damage awards in single judgment actions is also worthy of consideration to the extent workable methods of implementation may hereafter be developed.

D. Joint-and-several liability

6. The doctrine of joint-and-several liability should be modified to recognize that defendants whose responsibility is substantially disproportionate to liability for the entire loss suffered by the plaintiff are to be held liable for only that equitable share of the plaintiff's non-economic loss, while retaining liability for the plaintiff's full economic loss. A defendant's responsibility should be regarded as "substantially disproportionate" when it is significantly less than any of the other defendants; for example, when one of two defendants is determined to be less than 25% responsible for the plaintiff's injury.

E. Attorneys' Fees

7. Fee arrangements with each party in tort cases should be set forth in a written agreement that clearly identifies the basis on which the fee is to be calculated. In addition, because many plaintiffs may not be familiar with the various ways that contingency fees may be calculated, there should be a requirement that the contingency fee information form be given to each plaintiff before a contingency fee agreement is signed. The content of the information form should be specified in each jurisdiction and should include at least the maximum fee percentage, if any, in the jurisdiction, the option of using different fee percentages depending on the amount of work the attorney has done in obtaining a recovery, and the option of using fee percentages that decrease as the size of a recovery increases. The form should be written in plain English, and, where appropriate, other languages.

8. Courts should discourage the practice of taking a percentage fee out of the gross amount of any judgment or settlement. Contingent fees should normally be based only on the net amount recovered after litigation disbursements such as filing fees, deposition costs, trial transcripts, travel, expert witness fees, and other expenses necessary to conduct the litigation.

9. Upon complaint of a person who has retained counsel, or who is required to pay counsel fees, the fee arrangement and the fee amount billed may be submitted to the court or other appropriate public body, which should have the authority to disallow, after a hearing, any portion of a fee found to be "plainly excessive" in light of prevailing rates and practices.

15. Standards should be adopted substantially similar to those set forth in Rule 11 of the Federal Rules of Civil Procedure as a means of discouraging dilatory motions practice and frivolous claims and defenses.

16. Trial judges should carefully examine, on a case-by-case basis, whether liability and damage issues can or should be tried separately.

17. Nonunanimous jury verdicts should be permitted in tort cases, such as verdicts by five of six or ten of twelve jurors.

18. Use of the various alternative dispute resolution techniques should be encouraged by federal and state legislatures, by federal and state courts, and by all parties who are likely to, or do become involved in tort disputes with others.

H. Injury Prevention/Reduction

19. Attention should be paid to the discipline of all licensed professionals through the following measures:

(a) A commitment to impose discipline, where warranted, and funding of full-time staff for disciplinary authorities. Discipline of lawyers should continue to be the responsibility of the highest judicial authority in each state in order to safeguard the rights of all citizens.

(b) In every case in which a claim of negligence or other wrongful conduct is made against a licensed professional, relating to his or her profession, and a judgment for the plaintiff is entered or a settlement paid to an injured person, the insurance carrier, or in the absence of a carrier, the plaintiff's attorney, should report the fact and the amount of payment to the licensing authority. Any agreement to withhold such information and/or to close the files from the disciplinary authorities should be unenforceable as contrary to public policy.

I. Mass Tort

20. The American Bar Association should establish a commission as soon as feasible, including members with expertise in tort law, insurance, environmental policy, civil procedure, and regulatory design, to undertake a comprehensive study of the mass tort problem with the goal of offering a set of concrete proposals for dealing in a fair and efficient manner with these cases.

J. Coordinating Recommendations

21. After publication of the report, the AMA Action Commission to Improve the Tort Liability System should be discharged of its assignment.

HEALTH CARE COSTS and TORT "REFORM"

Attached is a chart showing the percentage of increase from 1982 to 1990 in personal health care spending per capita by state. It is derived from a February 1992 report entitled "Health Care Spending - Nonpolicy Factors Account for Most State Differences," published by the General Accounting Office (GAO). The GAO report utilized 1982 data compiled by the Health Care Financing Administration (HCFA) and 1990 estimates from Lewin/ICF.

Health care costs approximately doubled from 1982 to 1990 regardless of whether a state had enacted tort "reforms" and regardless of the type of "reforms" enacted, as is demonstrated by the attached chart.

For example, based on the figures utilized in the GAO report, the three states with percentage increases estimated to be slightly lower than average -- Arkansas, Kentucky and Mississippi -- had no caps on damages in medical malpractice cases. Alabama, with a slightly higher than average estimated percentage increase, had a cap on damages. Massachusetts and California, the two states with the highest estimated personal health care costs per capita, had in place a cap on damages.

*The attached chart was developed by the American Bar Association Special Committee on Medical Liability and the ABA Governmental Affairs Office, May 1993.
Contact: Lillian B. Gaskin, Staff Liaison to the Special Committee (202/331-2604).*

**Percentage of Increase from 1982 to 1990 in Personal Health Care Costs
Per Capita, State by State**

<u>1982</u> <u>RANKING/STATE*</u>	<u>1982</u> <u>HCFA data*</u>	<u>1990</u> <u>LEWIN/ICF Estimates*</u>	<u>% of INCREASE**</u>
1 Massachusetts	\$1,508	\$3,031	101
2 California	1,451	2,894	99
3 New York	1,417	2,818	99
4 Nevada	1,380	2,757	100
5 Rhode Island	1,351	2,707	100
6 Connecticut	1,348	2,699	100
7 North Dakota	1,325	2,661	101
8 Illinois	1,308	2,619	100
9 Missouri	1,285	2,568	100
10 Michigan	1,281	2,569	101
11 Pennsylvania	1,273	2,536	99
12 Kansas	1,271	2,548	100
13 Ohio	1,247	2,493	100
14 Maryland	1,232	2,436	98
15 Minnesota	1,229	2,480	102
16 Hawaii	1,228	2,469	101
17 Florida	1,228	2,427	98

<u>RANKING/STATE*</u>	<u>1982</u> <u>HCFA data*</u>	<u>1990</u> <u>LEWIN/ICF Estimates*</u>	<u>% of INCREASE**</u>
18 Wisconsin	1,219	2,449	101
19 Nebraska	1,216	2,452	102
20 Colorado	1,209	2,415	100
21 Alaska	1,187	2,367	99
22 Iowa	1,176	2,351	100
23 Washington	1,165	2,311	98
24 Oregon	1,165	2,312	98
25 South Dakota	1,154	2,322	101
26 Delaware	1,153	2,268	97
27 Tennessee	1,144	2,262	98
28 New Jersey	1,115	2,224	99
29 Arizona	1,112	2,211	99
30 Texas	1,110	2,192	97
31 Louisiana	1,106	2,185	98
32 Indiana	1,101	2,201	100
33 Maine	1,091	2,175	99
34 Oklahoma	1,086	2,139	97
35 West Virginia	1,057	2,088	98

<u>RANKING/STATE*</u>	<u>1982 HCFA data*</u>	<u>1990 LEWIN/ICF Estimates*</u>	<u>% of INCREASE**</u>
36 Virginia	1,054	2,076	97
37 Georgia	1,048	2,072	98
38 Montana	1,036	2,059	99
39 Alabama	1,033	2,286	121
40 Arkansas	994	1,944	96
41 New Hampshire	986	1,981	101
42 Vermont	978	1,956	100
43 Kentucky	957	1,875	96
44 North Carolina	931	1,833	97
45 New Mexico	904	1,792	98
46 Mississippi	897	1,751	95
47 Utah	896	1,784	99
48 Wyoming	873	1,756	101
49 Idaho	868	1,726	99
50 South Carolina	857	1,689	97
U.S. Average	1,220	2,425	99

* This data was obtained from a February 1992 GAO report entitled "Health Care Spending - Nonpolicy Factors Account for Most State Differences." Note that the Lewin/ICF estimates are not directly comparable with the HCFA data because the Lewin/ICF estimates also included administrative costs for private insurance which are excluded from HCFA's data on personal health care expenditures. GAO reported that it conducted its review "in accordance with generally accepted government auditing standards." HCFA estimates that 1990 U.S. personal health expenditures per capita averaged \$2,255.

** Rounded off to the nearest whole number.

RESOLUTION APPROVED BY THE
AMERICAN BAR ASSOCIATION
HOUSE OF DELEGATES
AUGUST 1988

Be It Resolved, That the American Bar Association supports the increased use of alternative means of dispute resolution in Federal administrative agencies consistent with the following:

A. General

1. Administrative agencies should adopt alternative methods of dispute resolution for resolving a broad range of issues. These techniques include arbitration, factfinding, minitrials, and mediation. The issues for which they may be employed include matters that arise in formal or informal adjudication, in rulemaking, in issuing or revoking permits, and in settling disputes, including litigation brought by or against the government.

2. Congress and the courts should not inhibit agency uses of the ADR techniques by requiring formality where it is inappropriate.

B. Voluntary Arbitration

3. Congress should act to permit executive branch officials to agree to binding arbitration to resolve controversies. This legislation should authorize any executive official who has authority to settle a matter on behalf of the government to agree to arbitration, either prior to the time a dispute may arise or after a controversy has matured, subject to whatever may be the statutory authority of the Comptroller General to determine whether payment of public funds is warranted by applicable law and available appropriations.

4. Congress should authorize agencies to adopt arbitration procedures to resolve matters that would otherwise be decided by the agency pursuant to the Administrative Procedure Act ("APA") or other formal procedures. These procedures should provide that:

- (a) All parties to the dispute must knowingly consent to use the arbitration procedures, either before or after a dispute has arisen.
- (b) The parties have some role in the selection of arbitrators, whether by actual selection, by ranking those on a list of qualified arbitrators, or by striking individuals from such a list.

APPENDIX C

(c) Arbitrators need not be permanent government employees, but may be individuals retained by the parties or the government for the purpose of arbitrating the matter.

(d) Agency review of the arbitral award be pursuant to the standards for vacating awards under the U.S. Arbitration Act, 9 U.S.C. §10, unless the award does not become an agency order or the agency does not have any right of review.

(e) The award includes a brief, informal discussion of its factual and legal basis, but neither formal findings of fact nor conclusions of law.

(f) Any judicial review is pursuant to the limited scope-of-review provisions of the U.S. Arbitration Act, rather than the broader standards of the APA.

(g) The arbitral award is enforced pursuant to the U.S. Arbitration Act but is without precedential effect for any purpose.

5. Factors bearing on agency use of arbitration are:

(a) Arbitration is likely to be appropriate where —

- (1) The benefits that are likely to be gained from such a proceeding outweigh the probable delay or costs required by a full trial-type hearing.
- (2) The norms which will be used to resolve the issues raised have already been established by statute, precedent, or rule, or the parties explicitly desire the arbitrator to make a decision based on some general standard, such as "justice under the circumstances," without regard to a prevailing norm.
- (3) Having a decisionmaker with technical expertise would facilitate the resolution of the matter.
- (4) The parties desire privacy, and agency records subject to disclosure under the Freedom of Information Act are not involved.

(b) Arbitration is likely to be inappropriate where —

- (1) A definitive or authoritative resolution of the matter is required or desired for its precedential value.
- (2) Maintaining established norms or policies is of special importance.
- (3) The case significantly affects persons who are not parties to the proceeding.
- (4) A full public record of the proceeding is important.
- (5) The case involves significant decisions as to government policy.

C. Mandatory Arbitration

6. Arbitration is not in all instances an adequate substitute for a trial-type hearing pursuant to the APA or for civil litigation. Hence, Congress should consider mandatory arbitration only where the advantages of such a proceeding are clearly outweighed by the need to (a) save the time or transaction costs involved or (b) have a technical expert resolve the issues.

7. Mandatory arbitration is likely to be appropriate only where the matters to be resolved —

- (a) Are not intended to have precedential effect other than the resolution of the specific dispute, except that the awards may be published or indexed as informal guidance;
- (b) May be resolved through reference to an ascertainable norm such as statute, rule or custom;
- (c) Involve disputes between private parties; and
- (d) Do not involve the establishment or implementation of major new policies or precedents.

8. Where Congress mandates arbitration as the exclusive means to resolve a dispute, it should provide the same procedures as in Paragraph 4, (b) - (g) above, except that judicial review should be pursuant to the Administrative Procedure Act, but with the courts' bearing in mind the purposes to be gained by arbitration.

**Statement
of the
American College of Surgeons
submitted to the
House Energy and Commerce Subcommittees on
Health and the Environment
and
Commerce, Consumer Protection and Competitiveness

RE: Medical Malpractice in Health Care Reform

November 10, 1993**

The American College of Surgeons is a voluntary, educational and scientific organization devoted to the ethical and competent practice of surgery and enhancing the quality of care provided to surgical patients. Founded in 1913, the College, in large part, was formed to undertake efforts to improve the quality of care of the surgical patient and the quality of the operating room environment. For over 80 years, the College has provided educational programs for its Fellows, who now number more than 60,000, and for other surgeons in this country and throughout the world. In addition, the College establishes standards of practice, disseminates medical knowledge, and provides information on surgical issues to the general public. It is with these interests in mind that the College offers the following comments on medical malpractice.

Patient Safety

The American College of Surgeons has been a pioneer in establishing a nationwide program for hospital accreditation, in developing standards for the training of surgical residents, in setting guidelines for high standards of preoperative and postoperative care, and in organizing the resources of surgery in an effort to improve the care of the critically injured patient and the patient with cancer. The College strongly supports the role of patient safety and quality assurance in our nation's health care system.

One method of improving patient safety is through continuous quality improvement systems. Continuous quality improvement systems establish indicators within institutions to discover and correct potential problems. If these systems are working properly, they will interrupt a sequence that may have otherwise led to an adverse event requiring physician privilege limitations. The Health Care Quality Improvement Act of 1986 supports this concept of continuous quality improvement. As stated in its findings, "... the need to improve the quality of medical care... can be remedied through effective professional peer review."

The College shares this view and has taken action. On the national level, the College has produced several information references for surgeons and their patients, including the *Professional Liability/Risk Management, A Manual for Surgeons*; the *Patient Safety Manual*, a guide for hospitals and physicians to a systematic approach to quality assurance and risk management programs; and two brochures for patients.

Recognizing that it is also useful for surgeons to take a proactive stance as advocates for their patients at the local level, the Ohio Chapter of the American College of Surgeons has developed an innovative program. It has established a separate foundation, Ohio Surgical Panel, Inc., to serve as a source for local qualified surgical experts. Through this foundation, a panel of surgical experts is convened for the purpose of examining disputes. Panels of surgical experts are available on a contractual basis for measuring quality assurance functions of individual hospitals, evaluating claims of defendant and plaintiff attorneys, reviewing peer review organization sanctions, and assessing various claims disputes on a case-by-case basis.

The Ohio Chapter believes that the quality of patient care is best maintained through participation of chapter representatives in hospital quality assurance activities. This participation should demonstrate to surgeons that the quality assurance proceedings are fair, objective, and not influenced by competition among physicians. Qualifications for serving on an expert panel include: (1) having practiced in Ohio for at least five years; (2) being in active practice; (3) having appropriate specialty training and board certification in the purported area of expertise; (4) practicing at least 50 miles from the area where any particular dispute occurred; and (5) holding membership in the Ohio Chapter of the College. In every situation, an academic surgeon in active practice is paired with a community surgeon in active practice. As this is a relatively new program, we look forward to learning more about its effectiveness over the next few years.

Despite these and other patient safety activities, medical liability continues to be one of the most severe problems facing practicing surgeons and their patients today, and it is one that adversely affects access, quality and the cost of health care in the United States. Medical liability may influence which patients or conditions that surgeons will treat, the number and types of diagnostic studies they will perform, and the types of treatments they will administer. The current system forces surgeons to practice medicine defensively and adversely affects the training of future surgeons. In addition, the legal costs and expenses of the current liability system, compared to the amount of payment that is awarded directly to patients, are often inequitable.

However, the College believes that the medical liability problem does not easily lend itself to a single solution. It is our view that several solutions, working in concert, could help remedy the crisis. Those solutions include: passing legislative reforms that allow for state demonstration grants to test alternative dispute resolution (ADR) systems; implementing federal tort reforms; and collaborating between hospital management and medical staff for systematic, hospitalwide programs designed to enhance patient safety.

The Administration's Plan

The College is pleased that the Clinton Administration has recognized that the federal government must address the problems of the current medical liability system, and that the proposed reforms offer several potential solutions. While the College is encouraged

that the shortcomings of the current medical liability system are being recognized, we are concerned that the proposed reforms are not strong enough to truly address the problems.

The Administration's proposal to develop a variety of mandatory ADR systems on a demonstration basis is not addressing the problem. ADR may provide patients who were negligently injured with quicker and more efficient access to the liability system. However, the College recognizes that the decisions made under ADR are not binding on either party. Without an incentive for resolving legal disputes outside of the courts, costs to the medical liability system may actually be increased.

As suggested in President Clinton's plan, certificates of merit have the potential of eliminating nuisance claims. This provision could be made stronger by strengthening the qualifications for the medical expert and by requiring that the medical records be reviewed and that a statement be filed as to the applicable standard of care, an opinion of how that standard was breached, an explanation of how that breach was the cause of injury, and actions that should have otherwise been taken.

A limit on noneconomic damages is the most essential element of meaningful medical liability reform. In its September 1993, background paper, "Impact on Legal Reforms on Medical Malpractice Costs," the Office of Technology Assessment stated that the one reform consistently shown to reduce medical liability cost indicators is a cap on noneconomic damages. Since insurance companies cannot actuarially calculate a realistic premium with

a knowledge of the risk to be covered, a cap on noneconomic damages is needed. Experience in certain states with caps may suggest that insurance rate savings are passed on to patients in the form of lower physician fees.

A cap on noneconomic damages does not prohibit an aggrieved individual from receiving compensation. Economic losses, such as lost wages, medical expenses, and rehabilitation costs, would be fully compensated. A reasonable \$250,000 cap on noneconomic damages would bring more economic stability to the medical liability system and still compensate individuals for pain and suffering.

The College would also urge the inclusion of a statute of limitations for medical liability claims so that claims may not be introduced after an extraordinary amount of time. Some claims, particularly in the case of minors, are filed years after the alleged injury is discovered. The cases are obviously difficult to remember, let alone defend, if many years have passed. In addition, negligently injured patients should receive their compensation as soon as possible.

The College is pleased that the President's plan includes a provision to modify the collateral source rule so that duplicative payments to claimants are eliminated. We also welcome the provision for periodic payment of future damages, since this practice benefits both the plaintiff and the defendant.

The College appreciates this opportunity to present its views on this issue, and urges your support for strong medical liability reform.



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